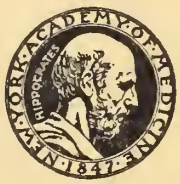
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THE JOURNAL

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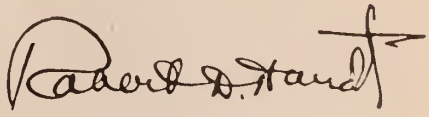
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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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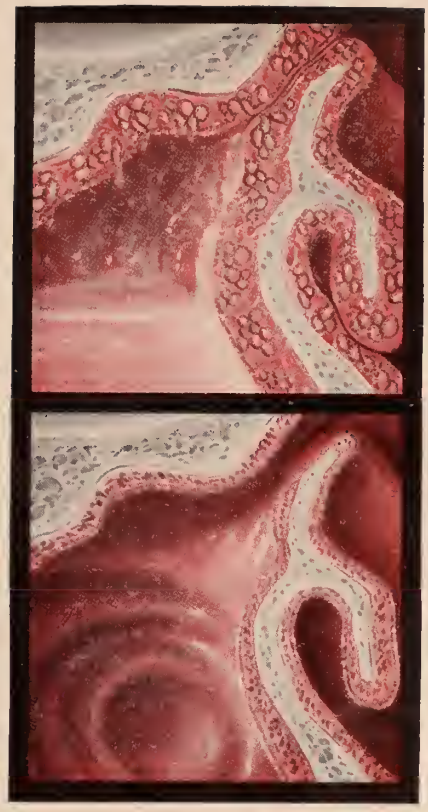
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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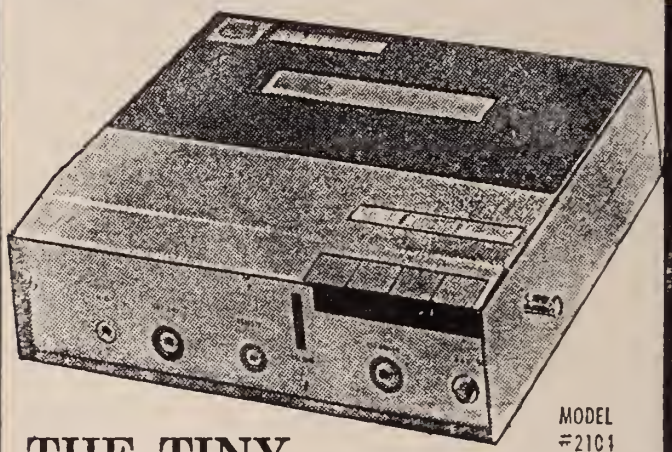
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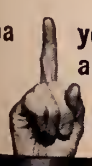


in bacterial
tracheobronchitis

Panalba*
promptly

to gain precious therapeutic hours

analba



your broad-spectrum antibiotic of first resort

In the presence of bacterial infection, taking a culture to determin bacterial identity and sensitivity is desirable—but not always practica in terms of the time and facilities available.

A rational clinical alternative is to launch therapy at once wit Panalba, the antibiotic that provides the best odds for success.

Panalba is effective (in vitro) against 30 common pathogens, inclu ing the ubiquitous staph. Use of Panalba *from the outset* (even pen ing laboratory results) can gain precious hours of effective antibiot treatment.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.
Usual Adult Dosage: 1 or 2 capsules 3 or 4 times a day.
Side Effects: Panmycin Phosphate has a very low order of toxicity comparable to that of the other tetracyclines and is well tolerated clinically. Side reactions to therapeutic use in patients are infrequent and consist principally of mild nausea and abdominal cramps.
Albamycin also has a relatively low order of toxicity. In a certain few patients, a yellow pigment has been found in the plasma. This pigment, apparently, a metabolic by-product of the drug, is not necessarily associated with abnormal liver function tests or liver enlargement.
Urticaria and maculopapular dermatitis, a few cases of leu penia and thrombocytopenia have been reported in patie treated with Albamycin. These side effects usually disapp upon discontinuance of the drug.
Caution: Since the use of any antibiotic may result in o growth of nonsusceptible organisms, constant observatior the patient is essential. If new infections appear during t apy, appropriate measures should be taken.
Total and differential blood counts should be made rout during prolonged administration of Albamycin. The possib of liver damage should be considered if a yellow pigmen metabolic by-product of Albamycin, appears in the pla Panalba should be discontinued if allergic reactions that not readily controlled by antihistaminic agents develop.

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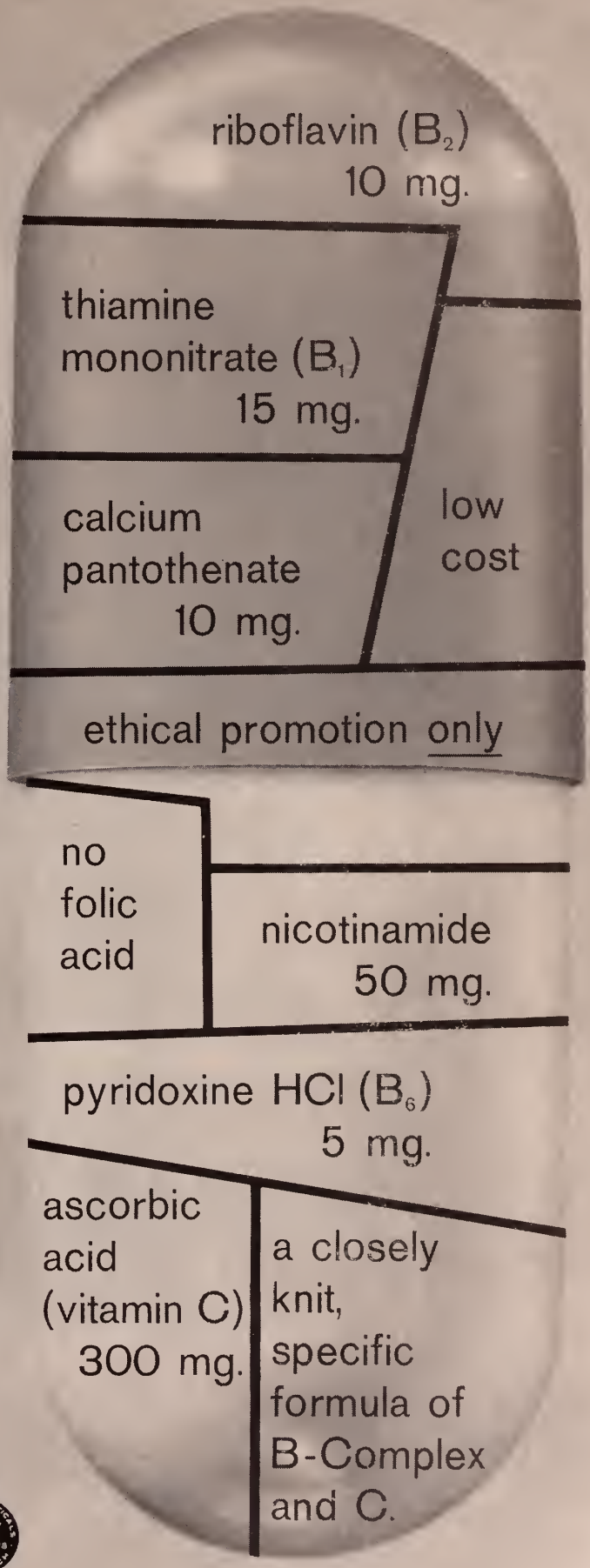
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KOAGAMIN®

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controls bleeding with minimal dosage and maximum safety

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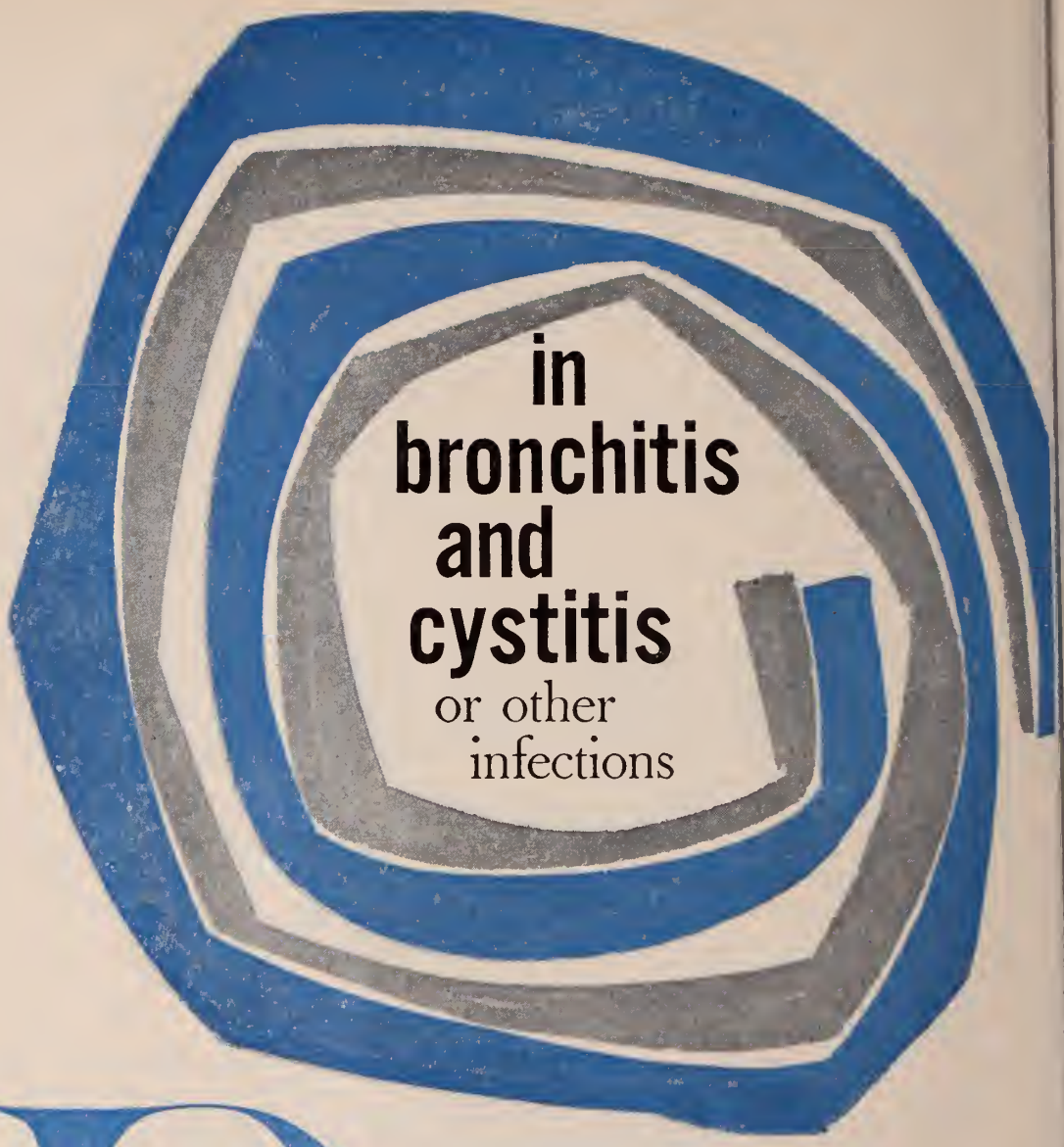
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CAPSULES, 150 mg., 75 mg. *Dosage:* Average infections—150 mg. four times daily. Severe infections—Initial dose of 300 mg., then 150 mg. every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. *Dosage:* 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into four doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored). *Dosage:* 3 to 6 mg. per pound body weight per day—divided into four doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics, and demands that the patient be kept under constant observation.

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EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
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Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children: ½ teaspoon (=2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

Winthrop LABORATORIES
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Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

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Brāsivol has a gentle abrasive action that attacks the acne lesion simply and directly. It maintains the mild desquamation so essential to the successful acne regime. Helps open plugged pores, reduce pustules and blackheads, control oiliness. Helps minimize postacne scars. The patient simply applies Brāsivol abrasive cleanser 2 or 3 times daily, and rinses. Ritual helps relieve urge to squeeze pimples. Cooperation is enhanced because results are readily seen and felt. Safety and success are supported in over 10 years of clinical studies on thousands of acne cases. Brāsivol (pat. pend.) contains precisely sized abrasive particles (fused aluminum oxide) and hexachlorophene 1%, in a detergent and drying base. Compatible with other therapeutic measures.

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Brāsivol is supplied in 3 abrasive grades, permitting gradual intensification of abrasive action as the acne improves. Also, Brāsivol Base (abrasive free) now available for acute inflammatory cases.

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REFERENCES:
SAPERSTEIN, R. B.: Treatment of Acne with Long Term Continuous Abrasion. A.M.A. Archives of Derm. 81: 601, April 1960.
REES, R. B.; BENNETT, J. H.; GREENLEE, M. R.: Newer Drug Treatment in Dermatology, Cal. Med., 91:1, July 1959.
SULZBERGER, M. B. & WITTEN, V. H.: The Management of Acne Today. Med. Clinics of No. America, 43:3, May 1959.



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(methylprednisolone)
a form for every use

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satisfactory results in 88% of cases

comments: "In practically every instance... the patients experienced relief from dryness and pruritus."

STUDY 2 *Lubowe, I. I.: Western Med. 1:45, 1960.*

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comments: Sardo "reduced inflammation, itching, irritation, and other discomfort..."

STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

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INDICATIONS

eczematoid dermatitis

atopic dermatitis

senile pruritus

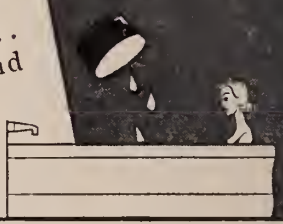
contact dermatitis

nummular dermatitis

neurodermatitis

soap dermatitis

ichthyosis



SARDO IN THE BATH releases millions of microfine water-miscible globules* which act to (a) lubricate and soften skin, (b) replenish natural emollient oil, (c) prevent excessive evaporation of essential moisture.

Patients appreciate pleasant, convenient SARDO.
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How Doctors Can Become PARTNERS in Profit From Investments in Giant Real Estate!



By Mortimer L. Schultz, one of the nation's leading Real Estate Syndicators, and President and Chairman of the Board, Office Buildings of America, Inc.

Mr. Schultz, author of "Partners in Profit—The Real Estate Syndication Story," has explained real estate syndication to hundreds of college, medical, executive and real estate groups throughout the United States. The questions below are representative of those most often asked by medical investment groups and from inquiries received from doctors.

Q What is real estate syndication?

A It is a group effort which permits the small investor to purchase income producing real estate that formerly was beyond his financial reach.

Q What are current yields and how are they paid?

A Yields currently range from 9 to 15% annually, paid on a monthly basis.

Q How can syndication benefit a doctor?

A Participation in syndication is an ideal way to convert ordinary income into long term capital gains, thus lessening the investor's tax burden.

Q Give a concrete example of how ordinary income converts to long term capital gains.

A A doctor with a $36,000 investment in a Newark office building received $38,760 in cash income during the syndication's five years of existence. Of this, only $10,000 was subject to tax, on a long term capital gains basis. In addition, the doctor was permitted to write off an additional $7,000 of income from his practice due to the depreciation reserves on the particular building.

Q What is the liability of an investing partner?

A A limited partner risks his investment only. Syndication shares usually range in price from $2,500 to $5,000.

Q Are partnership interests marketable?

A Definitely yes. First Jersey Securities was the originator and is still the nation's leading secondary market for syndications. In the past, First Jersey has had no trouble re-selling these shares, usually at par or better.

Q Who is the typical syndication partner and how much has been invested in syndications to date?

A A recent survey indicates the typical investor is (a) in his forties, (b) an executive or professional man with an income of $10,000 to $50,000 and (c) with $5,000 to $35,000 invested in two or more syndications. Syndication investments throughout the country are currently increasing at an annual rate of $3 billion.

For your complimentary copy of Mr. Schultz's new book, "Partners in Profit—The Real Estate Syndication Story," please fill in the coupon below.

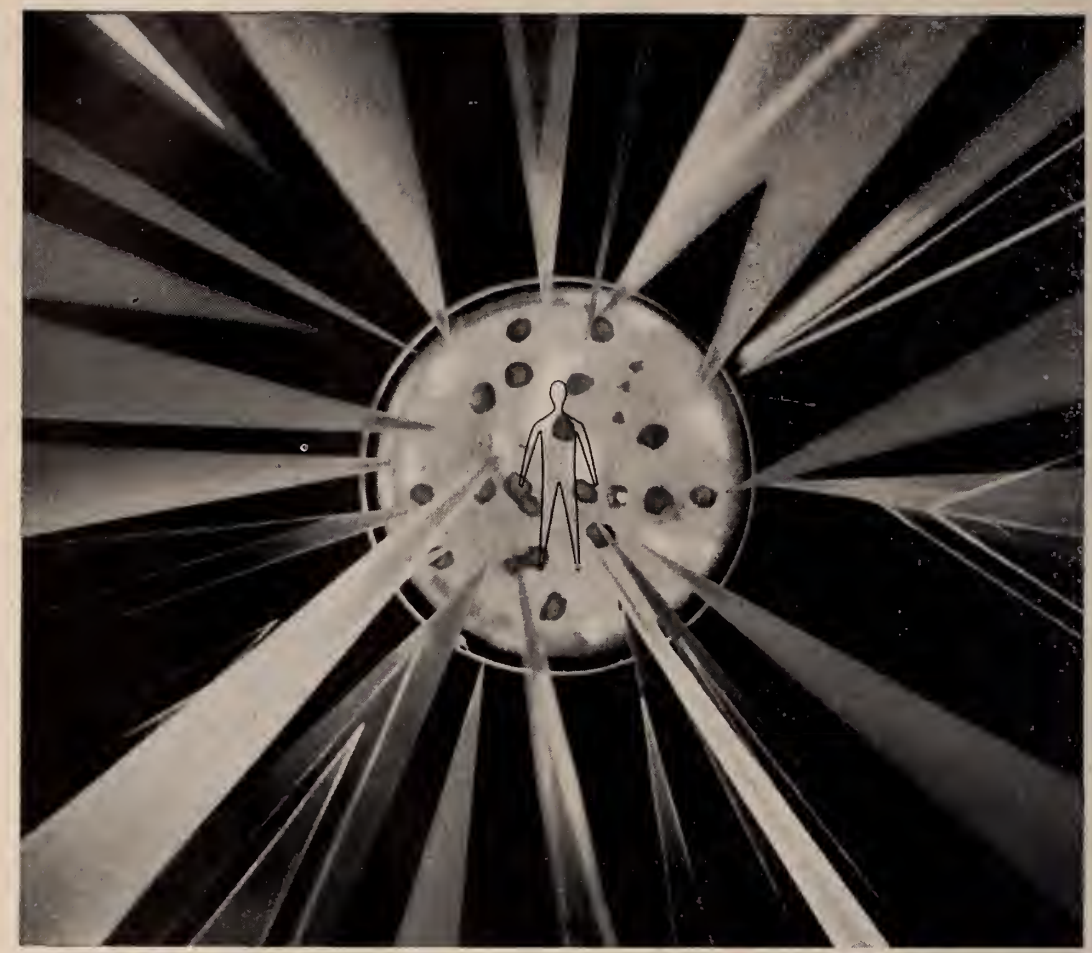
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because... it contains phosphate-potentiated tetracycline
for prompt, dependable broad spectrum antibacterial action.

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to prevent monilial overgrowth in the gastrointestinal tract.

Mysteclin-F resolves many respiratory, genitourinary and gastrointestinal infections—as well as such other conditions as cellulitis, bacterial endocarditis, furunculosis, otitis media, peritonitis, and septicemia. It combats a truly wide range of pathogenic organisms: gram-positive and gram-negative bacteria, spirochetes, rickettsias, viruses of the psittacosis-lymphogranuloma-trachoma group.

Available as: Mysteclin-F Capsules (250 mg./50 mg.) Mysteclin-F Half Strength Capsules (125 mg./25 mg.) Mysteclin-F for Syrup (125 mg./25 mg. per 5 cc.) Mysteclin-F for Aqueous Drops (100 mg./20 mg. per cc.)

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Squibb Phosphate-Potentiated Tetracycline (SUMYCIN) *plus* Amphotericin B (FUNGIZONE)

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How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

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It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh frozen, canned, or cartoned citrus fruit and juices.

When you suggest to your patient that they have a big glass of orange juic for breakfast, or for a snack, or whe they want to raid the refrigerator, th deliciousness of Florida orange juice wil give you assurance that they'll *want* t carry out your recommendation. You'l be helping them to the finest drink ther is—by the glassful or the barrel.

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And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

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Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

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"How do you feel lately, Mrs. K?" *"Well, Doctor, some customers still 'get on my nerves'... but somehow this doesn't bother me as much... I feel better now and people seem easier to get along with..."* "Feel sleepy?" *"No, nothing like that."*

In the treatment of mild to moderate tension and anxiety, the normalizing effect of TREPIDONE leaves the patient emotionally stable, mentally alert. Adult dose: One 400 mg. tablet, four times daily. Supplied: Half-scored tablets, 400 mg., bottle of 50.

this could be your "anxiety patient" on

TREPIDONE®

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Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

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Emotional control regained . . . a family restored . . . thanks to a physician and 'Thorazine'

During the past seven years, 'Thorazine' has become the treatment of choice for moderate to severe mental and emotional disturbances, because it is:

- specific enough to relieve underlying fear and apprehension
- profound enough to control hyperactivity and excitement
- flexible enough so that in severe cases dosage may be raised to two or three times the recommended starting level

Experience in over 14,000,000 Americans confirms the reassuring fact that, in most patients, the potential benefits of 'Thorazine' far outweigh its possible undesirable effects.

Of special value in mental and emotional disturbances: Tablets for initial therapy; Injection (Ampuls and Vials) for prompt control; Spansule® sustained release capsules for all-day or all-night therapy with a single oral dose.

Thorazine® brand of chlorpromazine
a fundamental drug in both
office and hospital practice
Smith Kline & French Laboratories

posed by professional models

'THORAZINE' PRESCRIBING INFORMATION

Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine® Reference Manual* and *Physicians' Desk Reference,* and from your SK&F representative or your pharmacist.

ADMINISTRATION AND DOSAGE

Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

ADULT DOSAGE

Mental and Emotional Disturbances (e.g., agitation, excitement, or anxiety)—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Alcoholism—Severely agitated patients: *Starting intramuscular dose* is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. **Agitated but manageable patients:** *Starting oral dose* is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

CHILDREN'S DOSAGE

For Behavior Disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery.

'Thorazine' Injection should not be mixed with other agents in the syringe. Because contact dermatitis has been reported with 'Thorazine', nurses or others giving frequent injections should avoid getting the solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight yellowish discoloration will not alter potency or efficacy. If markedly discolored, the solution should be discarded.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

CAUTIONS

Jaundice: The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals.

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease.

If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted.

Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vasoconstrictor is required, 'Levophed' and 'Neo-Synephrine'* are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Antiemetic Effect: The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

Neuromuscular (Extrapyramidal) Reactions: With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see *Physicians' Desk Reference*). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

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Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

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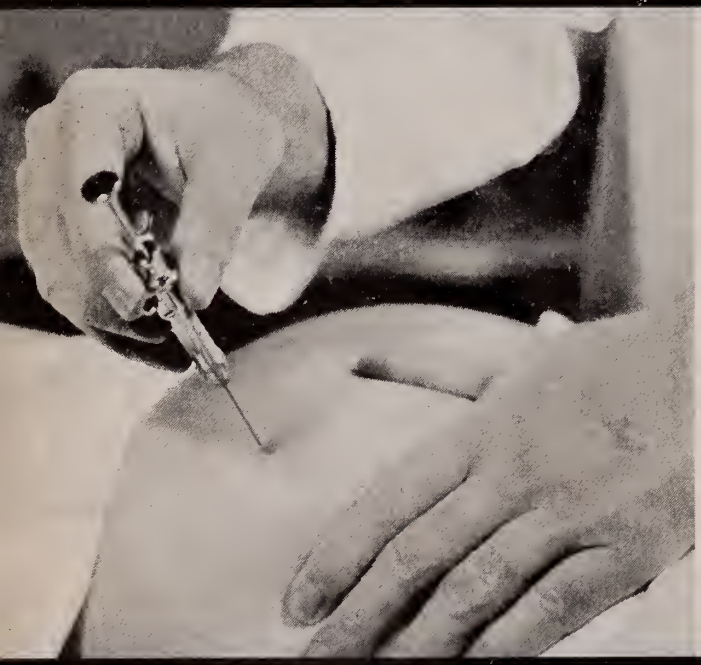
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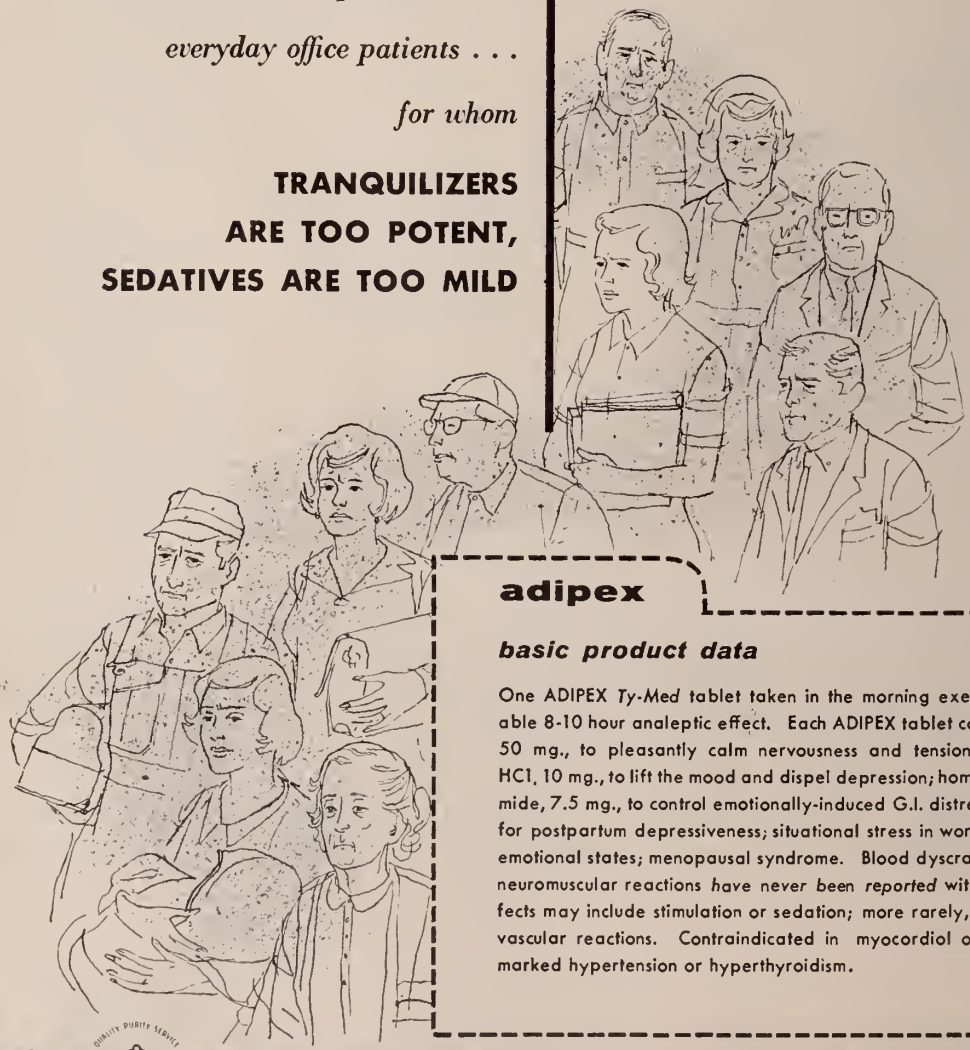
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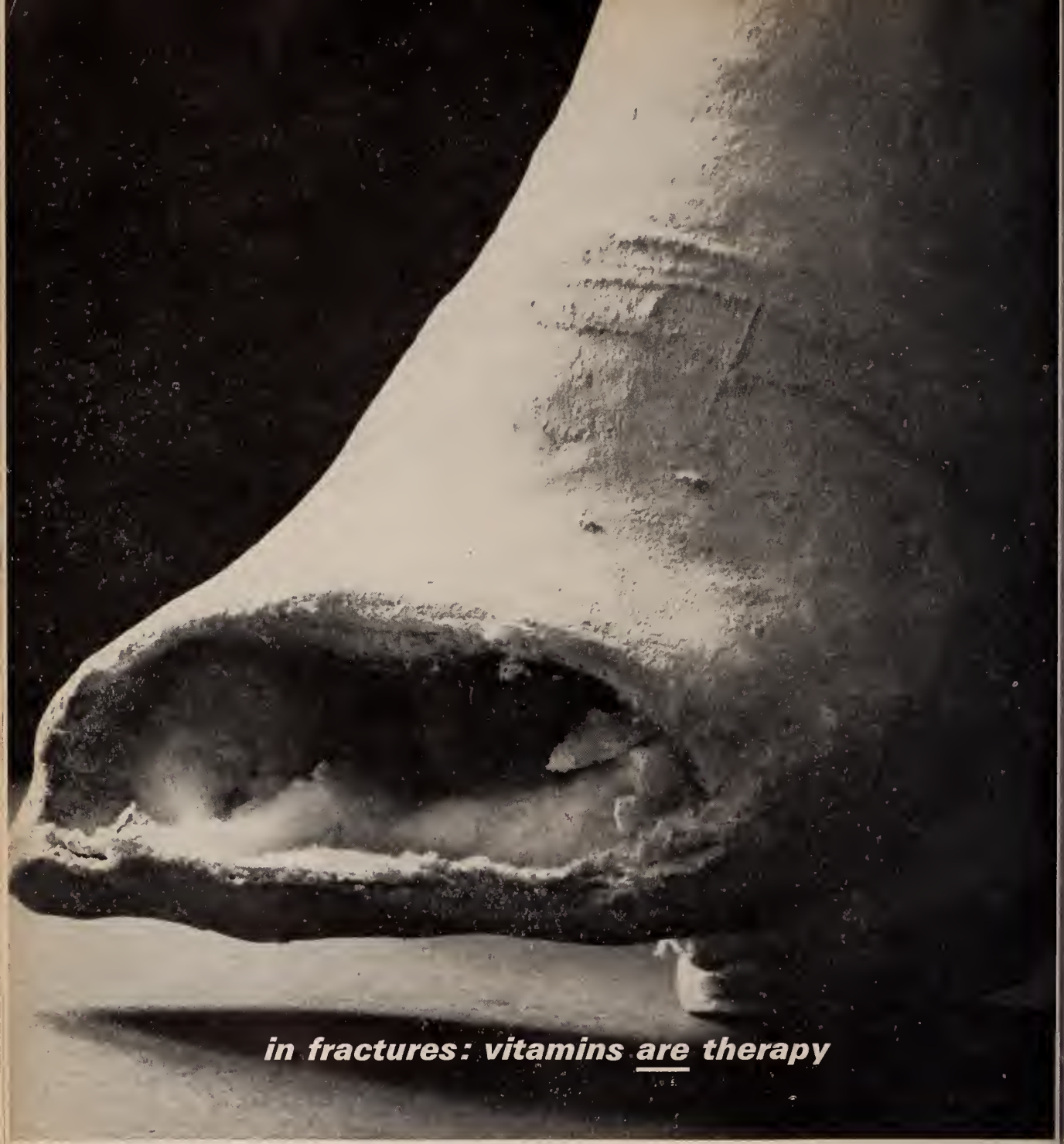
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Editorials • • •

Medical Care and Rising Prices

You hear a lot of talk about the swiftly increasing cost of medical care. Actually, most of the figures exaggerate that rise in relation to the sky-rocketting of other consumer prices. The CPI—"Consumers Price Index"—has risen 110 per cent since 1939. Physicians' fees have played a negligible role in this.*

Of the CPI's total rise, 96.8 per cent resulted from price increases of items *other than medical care*. Food costs influenced the rise by 55.5 per cent while medical care prices influenced it by 3.2 per cent—an average of one-sixth of one per cent a year.

Between 1949 and 1959, medical care prices accounted for only 8.5 per cent of the increase in the general price level, while housing and food account for 32.6 per cent and 29.9 per cent respectively.

The CPI has eight components—food, housing, apparel, medical care, transportation, personal care, reading and recreation, and other goods and services. Each is assigned a relative weight based on average annual expenditures for each component by urban wage-earner and clerical-worker families.

Based on an expenditure survey, the weight for the food component amounted to 35.4 per cent of the entire index in 1935-39. The weights for housing and medical care were 33.7 per cent and 4 per cent.

By December 1958, the relative importance of these components had changed to 28.7 for food, 32.7 for housing and 5.4 for medical care. With less of the family budget being spent for food and more for housing and medical care, a change in weights of these components took place. The last major weight revision was in 1952.

The weight shift occurred because family in-

*Statistical material is based on tabulations in the Aug. 22, 1960 American Medical Association *News*.

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comes have risen more than prices, and as real incomes and living standards increase, families tend to spend more on non-food items.*

Based on current weights, it would require a rise of 18.5 per cent in medical care prices to raise the CPI one per cent. In contrast, an increase of only 3 per cent in housing prices would bring a one per cent advance in the CPI.

Emphasis on medical care costs may be used to promote particular forms of legislative interference with the price mechanism and personal income distribution.

The Complete Physical

One of the by-products of advancing specialization is the decline of the complete physical examinations. General practitioners seem to be the only ones left who can do this, and they often become discouraged by the frequency of "normal" findings. There isn't much glamor in doing a really meticulous physical examination, and the constant re-iteration of "negative" becomes monotonous. Internists, who certainly *can* do complete examinations, often prefer to leave to the neurologist, the ophthalmologist, the orthopedist, the psychiatrist and the otologist the responsibility for invading those areas of the psychobiologic unit. Thus, it may come to pass, that "complete physical examinations" will be relegated to exercises for junior medical students.

Yet, as Ulrich† rightly says, "There is no more important factor in the development of a medical personality than that of making thorough physical examinations. It is like playing golf. You play your score of accuracies against previous scores. As you grow in efficiency so does your confidence grow . . . The use of your eyes, hands and ears never lets you forget that you are dealing with a human being. The fragmentations of the patient's physiology, no matter how they may illuminate the problem, are not the guiding spirit in your judgment . . . The condition and prognosis of the patient must be in his physical status—and that can be obtained only at the bedside."

There is even more to it than that. To begin with, there is the psychologic factor. To the layman, the symbol of the physician is the stethoscope, the tongue depressor and the blood-pressure cuff. The more thorough the examination, the more convinced that patient is that here is a friendly and scrupulous physician who knows what he is talking about. You and I know that many serious disorders do not, in early stages, manifest themselves in changes that can be picked up by physical examination. None the less, the psychologic impact is there, and in these days of self-criticism, is not to be neglected.

A careful examination is also a form of self-discipline. Cursoriness here becomes casualness in other facets of practice. It is also a technic of keeping up with medical progress. It is a way of re-establishing the thread of personal contact with patients that is threatened by the burgeoning of medical machinery. It is a recognition of the value of the laying on of hands. It is the badge of distinction of the physician. Many give health advice: nutritionists, psychologists, technicians, pharmacists, and others; but none do physical examinations, so this becomes idiomatic to the medical profession.

Oh yes—we almost forgot. You might even find something if you examined carefully enough and frequently enough.

†Ulrich, Henry: *Minnesota Medicine*, September 1961.
* See footnote on previous page.

The Physician as a Leader*

Psychologists divide mortals into two general classifications: one is called the subjective type, the other the objective. The subjective type of personality glories in working on his own responsibility and does his best work by himself with subordinate help, if any. He wishes to know more and more about some particular phase of human activity and to become expert in medicine, in engineering, or in the arts—he engages in research work—he dreams—he creates—he invents—by and large, he does the world's work. The objective type is exo-centric. He is the power and personality boy. He knows a little about a great many things and not too much about any one thing. He becomes the executive, the politician, or the statesman. He sells the work of the hands of the subjective type. In the main, the world is run by the objective type.

Some of us, of course, are altogether subjective or objective, while the majority of us have some of both characteristics but lean more strongly one way or the other. It now becomes apparent why physicians are not particularly successful in presenting their work, their cause, and their point of view; why they are not good politicians and why so frequently they squirm and wiggle because some layman is the executive who tries to direct and control their work and tell them how and where the work of their hands and brains should be carried out.

The old-time family physician, the doctor, was a generation ago the father confessor and adviser to persons, not only in matters of health but in economics and human relations of all kinds. He helped John secure finances for the purchase of a barn or more cattle; he gave Mary useful advice in matters of the heart. He must have been objective as well as subjective-minded since, in many, many ways, he was a power and influence in the community. As medicine has become more and more intricate, as the field of technical knowledge has expanded, too many of us have ceased to be "a doctor"—one who is learned—and have lost our interest for knowledge in fields other than those that concern our daily work; and so we have become highly trained technicians. Is it any wonder that we gradually, as subjective-minded persons, come under the control of the objective-minded members of the community? It is high time that we make a conscious effort to become partially objective-minded; that we seek positions in our community on Boards of Health or Education; that we run for the City Council, and that we once again exert our personality and intelligence and win back the esteem and the respect of the community because of our efforts for community welfare in general. We should once again produce our rightful proportion of leadership in all phases of human activity. The names of three physicians who were leaders in the political life of our country come quickly to mind—Benjamin Rush, one of the signers of the Declaration of Independence; William Newhall, Governor of New Jersey, Member of Congress, Governor of the Territory of Washington, and Organizer of the Life Saving Service along our coasts, and General Leonard Wood, with whose career we are all familiar. If we serve our fellow-men not only as skilled physicians but as intelligent leaders, we will be in a position to have our opinion in technical matters fully accepted because of our ability to lead in other lines. If we fail to assume such leadership, we will increasingly be forced to assume the role of the subjective technician objectively directed—such is the way of life.

William Gettier Herrman, M.D.

*Reprinted with permission from the July 1940 issue of *Radiology*. Although this was written 22 years ago, it is still valid and is worth repeating.

Original Articles • • •

HENRY A. BRODKIN, M.D.*

Newark

A Medical Program for Nuclear Defense

A Workable Plan

In this vigorous and practical blueprint, Colonel Brodkin speaks for himself, since no such plan has been officially adopted by any medical society or government bureau.

A PRACTICAL medical plan must be prepared to arouse interest and confidence in our apathetic public and to offer some assurance of surviving injuries after a nuclear attack. In a large measure, the lack of interest is due to fear that families may all be injured and helplessly imprisoned in underground shelters. Confusion is added to disinterest by opposing views of political leaders. Governor Rockefeller has sponsored a law to spend $100,000,000 for underground shelters for school children in New York. Yet such children spend 86 per cent of their time away from school. Senator Young of Ohio has stated that, in spite of an expenditure of a billion dollars, nuclear defense plans so far produced by the Office of Civil Defense are practically useless.

In spite of much discussion, a practical medical plan does not exist at any level. We are being lulled into security by a glamorized picture of medical operations following a nuclear attack. Looked at through a romantic haze, the Red Cross would come right in with all the needed food and medical supplies. The intact hospitals of the area would be emptied of their movable patients. The emergency plan would spring into swift action. Doctors would rush to the scene supported by pretty nurses and civilian defense workers in trim uniforms. Tents would be raised to house the sick, feed the homeless and treat the injured.

This is an idle dream. At this moment, there are hardly enough physicians in any area to care for the sick. Obviously, there will not be enough to handle the victims of a large scale nuclear attack. The same proportion of physicians will be killed and incapacitated as of other segments of the population; perhaps (in view of their exposure) even a higher proportion. Surrounding a target area, devastation will affect 2000 square miles, destroying most hospitals and other medical facilities in that zone. Water, gas, electricity and sewage facilities will fail. Roads and streets will be impassable because of debris and fires.

This country has done some creditable work in disasters like the earthquakes at Agadir, Africa and Chile. But these present only an infinitesimal fraction of the medical problem that will follow a nuclear attack on a metropolitan target in the United States.

The several levels of government are passing the buck to each other in assuming medical responsibility for Civil Defense. The National Office of Civil Defense Mobilization agrees to provide leadership and in-

*Dr. Brodkin is a Colonel (Retired) in the Army of the United States.

spiration; but feels that detailed operations cannot be directed from Washington and expects the States to do it. However, many of the problems involve traditional municipal functions like traffic control, police protection, fire fighting, emergency housing and food distribution. So the State expects the cities to do it. The situation in Newark is typical. Officials here are proud of the fact that they have stored some food and medical supplies in a number of underground shelters, in cellars of existing buildings. At that time I pointed out that Newark, lying in the shadow of choice targets, would be leveled to the ground in the event of a nuclear attack on the metropolitan area. Our buried food and medical supplies would then be hopelessly inaccessible. I suggested that the medical and food supplies be stored in caches behind the shield of a range of mountains 15 miles west of Newark. The suggestion was ignored. Now this proposal has become obsolete since the effective range of the bombs has multiplied. At the State level, there has been earnest thinking about many aspects of Civil Defense; but the medical phases have been ignored. Hospitals possess inadequate plans to take care of casualties resulting from a nuclear attack. However, we have been treated to pictures of empty streets during Civil Defense drills; and the pictures have made us and our officials feel smug and satisfied about our defense efforts.

BLUEPRINT FOR SURVIVAL

Concretely, here is a workable proposal for the medical facets of Civil Defense in the event of a nuclear attack.

1. *Autonomous Regional Target Areas.* The Director of the Office of Civil and Defense Mobilization could divide the country into 12 autonomous regional target areas corresponding to the U. S. Civil Service Regions. Each target area needs a director and staff to control all facets of civil defense in its zone, and be responsible to the National Director. The surgeon and his staff of each regional headquarters will supervise and be responsible for all medical problems relating to Civil Defense. His area may include four or five states. This will keep cities and states from engaging in inadequate and impractical defense activities because a nuclear attack on a target area would cross state lines. For example, a nuclear attack zeroed on New York City will involve at least five states. Similarly, such an attack on Region 1 will affect all the New England States and destroy its Civil Defense headquarters in Boston. If regional target areas 1, 2, 3 and 4 have been attacked, then all rescue measures must be directed from the remaining intact eight regional offices. In brief, a state cannot depend on its own defense measures with assistance from national headquarters if it suffers from a nuclear attack. This is impractical because defense measures could not function in that state, but must come from adjoining areas.

2. *Education in nuclear first aid.* Every American, old enough to do so, should be taught in school how to take care of himself and others when injured during a nuclear attack. Unless this is done, all defense measures will be stultified. This indoctrination is made easy by the fact that only six types of injuries of varying degree (lacerations, fractures, burns, concussion, radiation exposure and hysteria) could result. This training can thus be focused sharply on a few subjects. Underground shelters will greatly reduce the number of casualties; but there will still be hundreds of thousands injured inside and outside of them by flying debris, who will require treatment. If war becomes imminent, every person should be required to carry constantly, a gas mask and a sealed first-aid pack. This would avoid storage and transportation of medical supplies; and their immediate availability will reduce panic. A compulsory national education program in the treatment of these injuries must be initiated at once.

(a) *Children must be taught how.* The idea of teaching children these things may be objectionable. But let's face it: it is either learn or face avoidable suffering and even death. Every grammar and secondary school should include nuclear first aid in its curriculum. Let no child get a diploma until he has demonstrated, in pace with

his age and intelligence, the ability to give swift care to himself and others with such injuries.

(b) *Adults must be given courses* that will qualify them as first aid dressers, or other medical auxiliaries. Let there be no mistake about it: following a nuclear attack there will not be enough doctors. To survive we will have to depend on these amateur emergency "physicians."

(c) *As a matter of motivation and morale,* let there be special flags, and emblems worn or displayed in windows or doors showing that the family within has qualified.

(d) *A national immunization program* against tetanus and typhoid must be developed and enforced, after the initial series of injections have been given it will be necessary to give only one booster injection every four years to provide protection.

3. *Collection and triage of casualties.* An essential step, and one that must be taken *now,* is to plan predesignated collection points for casualties along the main roads radiating from ground zero of a bombed city or area. Here they will be sorted into five classes by teams consisting of a doctor and his lay assistants.

(a) Those who have given themselves or been given first aid treatment and are ambulatory will be directed for evacuation to designated places for food and shelter.

(b) Casualties who require further emergency treatment and motor transportation from the collection points to improvised hospitals, aid stations and surgical tent hospitals in the area. They would receive treatment by available doctors and be transported, for food and shelter, to designated towns and cities in the area or adjoining areas.

(c) Those who require major surgery or hospital treatment will be transported to the nearest functioning airports for air evacuation to intact cities and regional areas beginning with the nearest and then fanning out. Upon arrival they will be distributed to the hospitals which have been alerted and prepared to function properly in such an emergency.

(d) Casualties so seriously injured as to be beyond help and untransportable, are collected at designated places and given treatment by special teams for relief of pain and suffering.

(e) The dead are collected, identified and recorded by special teams and buried according to predetermined plans.

Triage (the sorting of casualties into these five classes) will save time, effort and increase the efficiency of the medical plan many times.

4. *Evacuation by air of class C casualties.* The seriously injured who require major surgery and definitive treatment must be evacuated to intact hospitals. This calls for detailed planning. The adjoining regional area headquarters would order all their hospitals to activate their emergency plans to receive at least double their normal capacity of patients. There will be no need to figure out routes of evacuation. There is only one route: the airways.

After casualties have been transported to cleared airfields in the bombed areas, they can be literally packed into passenger and cargo planes and in a few hours be brought to airports; and then to hospitals in unaffected areas anywhere in the United States. A modern passenger plane can evacuate about 100 casualties and make six round trips in 24 hours in a shuttle system within a radius of about 500 miles. The efficiency of this system is exemplified in a small measure by the existing aeromedical evacuation system of our Air Force which has been successfully functioning all over the world for the past nine years.

IN 1950, I suggested that in civil defense plans for Newark admission of casualties must be planned with the hospitals of Elizabeth, New Brunswick, Trenton and Philadelphia in addition to the intact surrounding hospitals in New Jersey. Today this would no longer suffice. Following a nuclear attack on the metropolitan target area now, most casualties will have to be evacuated to intact hospitals in Albany, Buffalo, Cleveland, Pittsburgh, Baltimore, Richmond, Louisville, Nashville, Atlanta and Jacksonville. There they will be treated by staff and teams of additional physicians in 12 hour shifts. Physicians can continue treating casualties for weeks under these conditions provided they are able to get proper rest and food. Better treatment would be given by bringing the casualties to the doctor in his hospital than bringing him into a devastated area.

Let us assume, as an example, that Region 2 (New York target area—the commercial center), Region 3 (Baltimore-Washington target area—the Government Center) and Region 7 (Detroit-Chicago target area—the industrial center) have suffered a destructive nuclear attack—this would be the most de-

sired primary objective of the enemy. The regional offices of all the intact areas east of the Mississippi would alert all their hospitals and these, in turn, would evacuate all movable patients and put into effect their civil defense plans to receive nuclear casualties. All large registered airplanes will (according to prepared plans) report to their area airports to establish a shuttle system of bringing casualties from the cleared airports in the attacked areas. After depositing the casualties on the airports of their assigned areas they can be loaded with all necessary supplies for the return trip. All these activities can be coordinated only through Regional Area Headquarters if plans for this function are established and practiced. Only by this means can hundreds of thousands of casualties be evacuated in a short time out of bombed areas.

SUMMARY AND CONCLUSION

I HAVE pictured a grim, catastrophic, devastating, unprecedented situation of gigantic proportion, the scope of which can scarcely be conceived. However, bombs that can do this are in the hands of human beings who may feel that they have been forced to use them. We must prepare accordingly. Half measures will not suffice. Our preparations to survive must be in proportion to the destructive potential of a nuclear bombardment.

365 Osborne Terrace

The Sign of Mongolism

One of the most exciting of recent breakthroughs in research into mental defect is the discovery that mongolism goes with an abnormal chromosome pattern. The discovery was made possible by advances in technics for studying human cells—improvements in staining methods, in methods of expanding the cell and separating the chromosomes. So it was shown that there are 46 chromosomes in normal men and women, 22 pairs called autosomes, unassociated with sexual characteristics, and one pair of sex chromosomes. Mongolism, or acromicria as it is also called, is associated with an additional autosome. This form of mental defect involves profound physical changes, notably obliqueness of the eyelids, breadth of the nose, and fissuring of the tongue, all of which produce the characteristic appearance that has led to the name "mongolism." There is no relationship between this condition and members of the human race inhabiting the Mongolian Plateau, despite the superficial resemblance. The defect is in fact so characteristic that when a child exhibiting it happens to be born to real Mongolian parents, there is no difficulty in distinguishing its appearance from that of the other children. Despite the fact that acromicrics have an additional autosome which appears to be responsible for their abnormality, all previous evidence suggested that hereditary transmission played only a very small part in producing this anomaly. The most consistent parental factor which appears to have significance in this respect is a comparatively advanced age of the mother; but even so it is common for the parents of an acromicric to have subsequent children who are entirely normal. The advance in our knowledge of the factors responsible for this particular form of mental defect may prove to be of very considerable importance, though as yet we have no way of influencing the pattern of chromosomal transmission in human beings.

World Mental Health, August 1961

H. P. Shipps, M.D

Camden

Pediatric Gynecology*

Even little girls can present gynecologic problems. Here Dr. Shipps swiftly and succinctly reviews the commoner ones.

Most physicians see pediatric gynecologic problems infrequently. Diagnosis may sometimes be difficult, and management uncertain. However, any physician may, on occasion, be confronted with gynecologic problems in children. Management falls particularly in the domain of the pediatrician and the gynecologist. It certainly behooves the gynecologist to be especially prepared and equipped to manage such cases. This presupposes familiarity with genital embryology, anatomy, physiology and endocrinology, as well as pathology and the principles of treatment.

Pathologic conditions affecting the female child are varied. Vulvo-vaginitis is the most common. Congenital anomalies and endocrine disorders do occur; and a child is not immune to neoplasia.

Adequate investigation of this area of medicine has sometimes been hindered by a reticence on the part of parents and physicians. Inspection of the external genitalia of the female child should be a part of routine examination. Careful gynecologic examination is essential whenever the history suggests that something may be gynecologically wrong.

This paper can touch only the high points of this subject; but I hope to stimulate a deeper interest on the part of all who attend children in their medical practice.

*Presented before the Section on Obstetrics and Gynecology, The Medical Society of New Jersey, Atlantic City, May 16, 1961.

THE HISTORY

With the infant or young child the story will be partly or entirely second-hand. The mother's story will be colored by her emotions. An accurate history may require piecing together information from the family and from the patient. It is obviously important to gain the confidence of the child. This is a major factor in good history-taking. Occasionally in the older child some advantage is gained, if one has established confidence, by planned inquiry in the mother's absence. The child may have some reason for withholding information from the family.

The experienced physician can usually evaluate the parental emotions and adequacies or inadequacies as they bear upon the child and problem at hand. Usually the parents need reassurance and simple, intelligible explanations and directions before much can be accomplished in treating the child. Effort in this direction is rewarding to all concerned. Sympathetic interest and patience are important, as well as firmness when the situation demands it. An intelligent, understanding and sympathetic nurse or assistant is indispensable.

THE EXAMINATION

The examination of these patients, as with all patients, must be both general and

pelvic. The routine should include the usual and special types of inspection and palpation, and on occasion, percussion and auscultation. It seems superfluous to suggest that these should be carried out with adequate exposure and lighting. In a high proportion of cases, even in small children, when the patient's confidence has been gained, the necessary examination can be done without anesthesia. However, on some occasions, examination under anesthesia is required. The pelvic examination requires meticulous and adequate identification of the urethra and vaginal orifice, and sometimes viewing of the vagina with a Kelly cystoscope or urethrascope. With gentleness, much can be learned by careful abdominal, rectal and combined recto-abdominal examination even in small children.

The ordinary gynecologic examining table is satisfactory. The following are found to be useful and necessary:

1. Cotton applicators, tightly wrapped.
2. Smooth metal probes and sounds.
3. Glass tubes or rods.
4. Rubber gloves and lubricant.
5. Infant speculum.
6. Glass slides.
7. Vaginoscope—Kelly cystoscope or urethrascope is useful.
8. Instrument for removal of foreign bodies.

Laboratory studies must be carried out as indicated. These will include blood counts, coagulation and bleeding time, blood platelet counts, metabolic rates or protein-bound iodine assays, bacterial smears and cultures and sensitivity tests, hormone assays; such as 17-ketosteroids, estrogens and gonadotropins, also biopsies, cytology and various x-ray procedures. To these should also be added the occasional need for determination of chromosomal sex.

DEVELOPMENT DURING CHILDHOOD AND ADOLESCENCE

DURING the early postnatal years there is little evidence of special genital or sexual development. A working knowledge of the normal is important. Genital changes early are more in keeping with growth generally.

With the onset of adolescence the reproductive system takes on accelerated activity. The physician must recognize at this time that there may be individual differences, both as to timing and pattern, which are within the range of the normal. Usually at this time there occurs a spurt in growth evidenced in bone and muscle. Breast development and development of pubic hair are usually the first signs of puberty. This may occur any time between age 8 and 13 years. Axillary hair usually appears before the pubic hair has completed its development. In a few children the axillary hair may appear first. Associated with axillary hair growth is enlargement of the sweat glands locally and generally.

Increased development in the vagina and uterus probably begins about the time the breast bud appears. Soon the bacterial flora of the vagina are dominated by the lactic acid-forming Doderlein bacillus. The reaction of the vagina then becomes acid. Secretion of estrogen at this time thickens the vaginal mucosa and deposition of glycogen creates a favorable environment for the Doderlein bacillus.

Estrogen also produces increase in size of the uterus. This effect is relatively greater on the corpus uteri. Both endometrium and myometrium are involved. Estrogen also produces extra-genital effects manifested by weight-gain, increased height, and so on.

The menarche (onset of menstruation) is the next stage in development. This occurs at about the end of the events of adolescence. It does not, however, mark the attainment of full reproductive activity or function. The earlier menstrual cycles are likely to be anovulatory and irregular. Regularity of menstrual pattern is generally not established for about a year. Primary dysmenorrhea is a rare occurrence the first year probably because the periods are anovulatory.

The average age at which the first menstrual period occurs in North American girls is at present a little under 13 years, according to Tanner.[1] There is some variance depending upon social status, nutrition, race, and climate.

1. Tanner: Clin. Obs. & Gyne., Vol. 3, No. 1, p. 142.

Normal variation is from age 11 years to 15 years. Over the past century in the United States, the menarche has been getting earlier by about 4 months per decade.

The clinician must recognize considerable variation in development within normal limits in the child and not be too quick to assume pathology. One particular point in this relation is the occasional development of one breast in advance of the other. It would be unfortunate to treat this radically as a neoplasm.

CONGENITAL ANOMALIES

Congenital absence of the vagina is not common. It results from failure in the Mullerian system, usually associated with absence or incomplete development of the uterus. It is also at times associated with abnormalities in the urinary tract. This necessitates at least intravenous urograms in the study of these cases. The external genitalia usually appear normal except that the vaginal introitus is absent or very shallow. Since the ovaries arise from a different embryonic structure (the genital ridge) secondary sex characteristics are usually normal.

Congenital absence of the vagina is rarely associated with a normal uterus and tubes. After reconstruction of the vagina such patients may have a normal reproductive life. The patient with absence of the uterus and vagina, after vaginal reconstruction can usually have normal coitus. It is, however, important that the condition be diagnosed well in advance of marriage to avoid serious embarrassment. Ideally, however, the reconstruction should be performed a few months prior to marriage, so that the necessary continued dilatation may be carried out naturally.

Other types of vaginal malformation do occur; such as septae. These are most frequently found in the middle and upper vagina; and the management is usually relatively simple.

Labial adhesions are the result of inflammation rather than congenital anomaly, but they are mentioned here because the condition may be mistaken for absence of the vagina in small children, unless careful examination is carried out. The condition is usually easily corrected. On digital separation of the labia one will notice a line running between the labia representing fusion at the vaginal orifice. Frequently with a small probe and a cooperative patient one can readily find the vaginal orifice as distinct from the urethral meatus. It is not necessary to probe this extensively or attempt by this maneuver to "cure" the situation. Daily application of an estrogen cream by the mother will usually suffice to clear up the condition painlessly.

Imperforate hymen is reported in about one in every 1,000 to 2,000 gynecologic admissions.[2] It is not usually suspected in the very young, but is most commonly found after adolescence is well progressed, when the menstrual flow does not appear. The flow accumulates in the vagina, uterus and tubes with the development of lower abdominal pains and a mass. Examination reveals a bulging imperforate hymen and a cystic mass in the vagina and extending into the abdomen. Laparotomy for abdominal pathology without first doing an adequate pelvic examination could be embarrassing in such cases. Hymenotomy produces prompt relief of symptoms and eventual cure.

Hydrometrocolpos or hematometrocolpos may occur in the very young female associated with imperforate hymen. A newborn infant may accumulate several hundred cubic centimeters of fluid behind the hymen as a result of maternal hormonal stimulation. Ulfelder and Hendren[3] present a picture of such a case.

Pseudo-hermaphroditism is not a common occurrence. Partial masculinization of the external genitalia of female babies has been reported a number of times recently as a result of large doses of progestational hormones administered to pregnant women.

Bicornuate uterus may occur in the small child but discussion of this seems beyond the

2. Rosenthal, *et al.*: Am. Jour. Surg., 95:487, 1958.

3. Ulfelder and Hendren: Clin. Obs. & Gyn., Vol. 3, No. 1, p. 183.

scope of this paper as the condition is generally not detected until adult life, occasionally at the menarche.

GONADAL DYSGENESIS

Gonadal dysgenesis has been occupying increased attention in recent years and is being diagnosed not only in the adolescent child but also in the newborn. The condition is also called congenital rudimentary gonadal syndrome, congenital aplasia or hypoplasia of the gonads, syndrome of rudimentary ovaries or Turner's syndrome.

In the adolescent girl it is characterized by sexual infantilism in an otherwise genitally normal female, resulting from lack of function of the rudimentary ovaries. Hamblen [4] reports that 80 per cent of these patients are chromatin-negative and 20 per cent chromatin-positive. Chromatin-negative girls are evidently *not* male pseudo-hermaphrodites as they have no Y chromosomes, but instead an XO chromosomal status with a total count of 45 chromosomes instead of 46.

These patients do not have defects in their Mullerian duct system. However, they may have defects in some other body systems. Such girls are generally short in stature or have webbed necks, and show lack of development of secondary sex characteristics. At puberty the pituitary attempts to stimulate the ovaries, but there is no response. High levels of gonadotropins are found at this time. The 17-ketosteroids are usually normal, but occasionally low. There is usually retardation in dental and osseus development.

Treatment consists of cyclic estrogen—progesterone therapy, with the hope of producing secondary effect on bones, soft tissues and psyche, and the maintenance of an adequate vaginal tract despite the usual infertility.

In the newborn, gonadal dysgenesis may be diagnosed, according to Richart,[5] by firm, nonpitting edema of both hands and feet, a short neck, sometimes webbing of the skin of the neck, low hair line on the back of the neck and sometimes "low-set" ears. All four babies reported by Richart [5] had normal appearing external genitalia and chromatin-negative (male) nuclear chromatin pattern. Obstetricians and pediatricians are becoming more alert in picking up these cases.

FEMALE PRECOCITY

Female precocity may be constitutional or organic. The former constitutes about 90 per cent of the cases.[6] Thus, the usual cause of precocious sexual development is *not* some organic lesion, but only the early onset of an otherwise normal puberty. This is an important practical point to keep in mind.

Organic causes of female precocity include cerebral lesions involving the posterior hypothalamus, granulosa-cell tumor or theoma of the ovary, and rarely a lesion of the adrenal gland. The adrenal lesion usually produces virilization.

A number of cases of female precocity have been reported resulting from ingestion of estrogenic hormones by small children, accidentally or otherwise.

NEOPLASIA

Pelvic tumors in children are not common. The gynecologist, however, must be familiar with those that may occur in order to make reasonable differential diagnosis dealing with varied genital abnormalities.

The most frequently seen malignant tumor of the uterus and vagina in children is sarcoma botryoides. It grows in a manner resembling white grapes. It is a highly malignant lesion and very few 5-year survivals are reported. Radical surgery is the treatment of choice, since, like most sarcomas it is usually radio-resistant.

4. Hamblen, *et al.*: Clin. Obs. & Gyn., Vol. 3, No. 1, p. 207.
5. Richart and Benirschke: Obs. & Gyn., Vol. 15, No. 5, p. 621.
6. Jolly: Clin. Obs. & Gyn., Vol. 3, No. 1, p. 204.

Benign tumors of the vagina and uterus are even more rare.

Ovarian tumors in childhood (which are rare) may be benign or malignant. Some are hormonally active; *i.e.*, estrogen or androgen-producing. Congenital anomalies of the uterus with development of hematometra and hematosalpinx in the adolescent girl are sometimes involved in differential diagnosis.

In 1959 Charache[7] reported six cases between the ages of two and 15 years. One had a malignant teratoma; one had bilateral malignant dysgerminoma; two had bilateral ovarian carcinoma, one had unilateral carcinoma of the ovary; and one had a fibroma. He reviewed 257 other cases. Progressive abdominal enlargement, abdominal mass, and abdominal pain were the chief complaints. There may be associated nausea, vomiting, fever and leukocytosis, giving a picture of an acute "surgical abdomen." Pressure on the urinary or gastrointestinal tract may give symptoms referable to these systems. Laparotomy is generally required for ovarian tumors in children. If the tumor is unilateral and well-encapsulated, without evidence of spread, conservative surgery is in order, being careful not to rupture the capsule during the removal. Radical surgery, followed by irradiation and/or chemotherapy is indicated in proved malignancy with metastasis.

TRAUMA

INJURIES to the vulva or perineum are usually the result of a fall upon some sharp object. Traffic accidents sometimes result in severe injuries to this area. The physician must take appropriate measures to diagnose and repair any injuries to the urethra, bladder, peritoneum or bowel, as well as the vagina. These injuries may not be evident upon superficial examination.

Attempted rape may also be the cause of severe injury. Utmost care in evaluation is important to avoid embarrassment. A small child may present a widely patent hymen without injury. Conservatism is wise in drawing serious deductions unless frank evidence of trauma is present; *e.g.*, bruising, bleeding, or fresh laceration. Vulvar injury is not proof that rape has been attempted or committed. Smears and washings should be examined for spermatozoa, and articles of clothing should also be examined. Careful, pertinent records must be made and kept for medico-legal use.

7. Charache: A.M.A. Archives of Surg., 79:573 (Oct.) 1959.

FOREIGN BODIES

FOREIGN bodies may be difficult or easy to diagnose. They may range from paper to wood or glass or metal or crayon. Some can be easily elicited by touching with a metal probe or sound. This maneuver may sometimes be enhanced by the simultaneous presence of an examining finger in the rectum. X-ray is only of limited usefulness. Examination with a Kelly cystoscope or urethrascope or some similar instrument may be the only solution in some situations. Suspect a foreign body in a small child with evidence of vaginitis. Treatment is removal of the foreign body and appropriate therapy for the infection.

INFECTION

IRRITATIONS and inflammations of the vulvar area are the most common conditions that bring the female child to the gynecologist. The mother notices some unusual appearance of the child's vulvar area; or the child may complain of distress in the area. Usually the process involves only the vulva (vulvitis), is nonspecific, and will respond to simple cleanliness and hygiene. It may be self-produced (by manipulation) or may be the result of fecal contamination. Later results of this condition may be labial adhesions and closure of the vaginal outlet.

If the infection involves the vagina also (vulvovaginitis) it is not as easily managed in small children. First, the possibility of for-

eign body should be eliminated; and smears and cultures taken for isolation of the offending organism or organisms. Sensitivity tests with antibiotics will indicate the most likely best weapon against the offender. In most cases the therapy should be local. In some, systemic treatment may be indicated.

The use of estrogens in these situations does not seem to be as popular in recent times, although the maturing effect of estrogens on these immature tissues (with the resultant improved resistance to infection) cannot be denied. This must not be forgotten in treating the pre-adolescent child.

SUMMARY

A RESUME of some of the gynecologic conditions confronted by the physician who treats children has been presented with some suggestions regarding their management.

719 Cooper Street

Physicians and Adoption

In a survey of physicians on the subject of adoption, 84 per cent of the more than 5,000 who responded said they believed their role in adoption should be to refer the couple to a recognized adoption service, while 16 per cent said that placement should be by the physician, independent of agencies, where legal. This was reported in *Patterns of Disease*, a Parke, Davis & Company publication for physicians.

Most common reason for children being placed for adoption, according to 90 per cent of physicians who responded, is illegitimacy. Others cited such factors as the child not being wanted, economic insecurity, desertion of one parent, and death of one or both parents.

"Physicians share the general impression that adoption can trigger pregnancy in seemingly infertile couples." In reporting on a survey, to which more than 5,000 physicians responded, *Patterns* said that in reply to the question 'Is it your impression that seemingly infertile couples who adopt children subsequently have children of their own?" 55 per cent answered yes, eight per cent sometimes or occasionally, and 34 per cent answered no.

Aging Skin

Blame aging and wrinkling of the skin on the cumulative amount of sunlight exposure, not on age *per se* or complexion. This is the conclusion of a study reported by the Department of Dermatology and Pathology, Baylor University College of Medicine, Houston, Texas.

Skin specimens were examined from young, middle and old age groups for actinic degeneration. All types of complexions from light to dark were included. "None of the sections from the buttocks showed degenerative changes. In considering sections from face and arm, the older patients showed the most severe damage, presumably due to the cumulative ultraviolet dosage," the findings showed. "The degree of degenerative change also correlated well with information . . . relating to the degree of sunlight exposure, with those having most severe exposure demonstrating the most extensive changes."

From these data the dermatologists concluded that the onset of degeneration is independent of age, "being determined by the cumulative amount of injury from ultraviolet light."

COCKERELL, E. G.,
Archives of Dermatology, 84:467 (September) 1961.

Roscoe P. Kandle, M.D.*

Trenton

Recommended Treatment of Persons Bitten By Animals

Doctors are expected to know—but often don't —the immediate management of animal bites. Here is a ready reference refresher.

Confirmation of rabies in six bats and one cat captured in New Jersey in the last year establishes the presence of rabies virus in our state and accentuates the importance of swift and effective treatment of humans bitten by animals. The following information is offered for the guidance of physicians.

Reporting Animal Bites

Under the provisions of Revised Statutes 26:4-79, 80, and 81, the name, age, sex, and precise location of any person bitten by an animal *must* be reported to the local board of health. The report is made by the physician attending the person bitten, by the parent or guardian of a child bitten, or by an adult bitten when no physician attends.

It is expected that investigation to determine the exact circumstances of exposure will then be conducted by the municipality in which the bite occurred, in which the bitten person resides, and/or in which the animal is maintained. Instruction and consultation will be provided by the State Department of Health. The Department will conduct such investigations if qualified local health persons are not available.

The Biting Animal

Any animal which bites a person should be caught alive if possible, dead if necessary.

The live animal should be confined for at least ten days in an enclosure suitable to prevent escape. Local boards of health have authority to confine an animal which has attacked or bitten a person. Confined animals should be observed by a veterinarian during the period, in order to detect signs or symptoms suggestive of rabies. If an animal is confined by some person not qualified to determine or diagnose clinical signs of rabies, the animal should be *immediately* examined by a licensed veterinarian, if it shows any of the following during its period of confinement: change in disposition, unusual nervousness or irritability, a tendency to bite without provocation, a change in voice, dropping of the lower jaw, weakness of the legs, anorexia, or twitching of muscles.

Submission of Brain for Laboratory Examination

The local board of health should arrange to submit to the State Department of Health (or other laboratory listed below) the heads of animals killed during capture or which die within ten days of the bite. *Heads should be*

*Dr. Kandle is the New Jersey State Commissioner of Health.

delivered by messenger to the laboratory and not sent by commercial carrier or mail.

Heads may be delivered to the State Department of Health Laboratory, 4th floor of the State House in Trenton, *at any hour, any day.*

Board of Health, City Hall, Elizabeth
County Board of Health, County Administration Building, 595 Newark Ave., Jersey City
Irvington Health Center, 31 Glorieux Street, Irvington
Health Department, 77 Arlington Street, Newark
Health Dept., Mill and Passaic Streets, Paterson

BATS

THE bat is the exception to the rule regarding ten-day confinement of biting animals. Bats may live more than ten days after the virus is present in the saliva. A ten-day confinement period may give a false impression that the bat could not have transmitted rabies at the time of the bite. The biting bat should be delivered to the laboratory in a jar or similar container in which it can be destroyed while at the laboratory.

OTHER LABORATORIES AVAILABLE

IN ADDITION to the New Jersey State Department of Health laboratory, the following laboratories are available for limited local service:

Bergen Pines County Hospital, Paramus
Health Department, 143 New Street, East Orange

POST-EXPOSURE TREATMENT

EARLY, vigorous local cleansing is of primary importance in preventing infection. Wash the wound thoroughly with soap or detergent and flush thoroughly with water. The wound should *not* be immediately sutured, unless such action is strongly indicated in accord with necessary surgical procedures. If the recommended treatment includes the use of antirabies serum, part of the serum dose should be infiltrated about the wound. Apply antiseptic after the foregoing procedures. Cauterization is not recommended as a normal procedure. Tetanus prophylaxis should be instituted promptly in all cases of animal bites by the use of a booster dose of fluid tetanus toxoid.

The following guide outlines recommendations of the New Jersey State Department of Health for specific post-exposure treatment:

GUIDE FOR SPECIFIC POST-EXPOSURE TREATMENT

Biting Animal

Nature of Exposure		At Time of Exposure	During Observation Period of Ten Days	Recommended Treatment (in addition to local treatment)
I. No lesion: indirect contact		Rabid	—	None
II. Unprovoked bites with mild exposure	a.	Healthy	Healthy	None
	b.	Healthy	Clinical signs or proved rabid	Start vaccine at first clinical signs in animal.
	c.	Signs suggestive of rabies	Healthy	Start vaccine immediately. Stop if animal is normal on 5th day after exposure.
	d.	Presumed rabid, escaped, killed, or unknown	—	Start vaccine immediately.
	e.	Wild (fox, bat, skunk, etc.)*	—	Start vaccine immediately.

III. Unprovoked bites with severe exposure (multiple, or face, head, finger or neck bites)	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proved rabid	Serum immediately; start vaccine at first sign of rabies in biting animal.
	c. Signs suggestive of rabies	Healthy	Serum immediately followed by vaccine: vaccine may be stopped if animal is normal on 5th day after exposure.
	d. Presumed rabid, escaped, killed, or unknown	—	Serum immediately followed by vaccine.
	e. Wild (fox, bat, skunk, etc.)*	—	Serum immediately followed by vaccine.
IV. Bites where provocation exists	a. Healthy	Healthy	None
	b. Healthy	Clinical signs or proved rabid	Start vaccine at first sign of rabies in animal.
	c. Signs suggestive of rabies	Healthy	Start vaccine immediately. Stop if animal normal on 5th day after exposure.
	d. escaped, killed, or unknown	—	Incidence of rabies in N. J. is so low that the possibility of adverse effects from vaccination outweighs the risk of rabies. If there is a change in the incidence of rabies, all physicians will be so notified, and recommendations modified.
	e. Wild (fox, bat, skunk, etc.)*	—	Start vaccine.

* Rats, mice and hamsters appear to be of very little importance as transmitters of rabies in this area. Persons bitten by these animals should *not* receive specific post-exposure treatment, unless the reported activities of the animals are so distinctly unusual as to be highly suggestive of rabies.

The manufacturer's recommendations should be consulted prior to use of serum and vaccine.

Antirabies serum, if used, should be administered as soon as possible, preferably within 72 hours of exposure. Antirabies serum should be administered in a dose of 40 international units per kilogram (2.2 pounds) of body weight. *Sensitivity of the patient to the serum should be tested before serum is used.* A portion of the dose should be infiltrated around the bite. Under no circumstances should additional serum be administered. Subsequent doses may interfere with the response to rabies vaccine.

Duck embryo rabies vaccine is prepared for subcutaneous injection in doses of one cubic centimeter daily for 14 days. In all cases where serum is followed by a full course of vaccine, it is suggested that two supplemental doses of vaccine be administered at 10 and 20 days following completion of the usual vaccine schedule.

PROCUREMENT OF SERUM

ANTIRABIES serum may be obtained by calling the following:

	Business Hours	Other Times
Mr. Lyle Cook	EXport 2-2131, Ext. 8341	TUxedo 2-1944
Dr. William J. Dougherty	EXport 2-2131, Ext. 8239	EXport 6-6067
Mr. John B. Van Ellis	EXport 2-2131, Ext. 279	EXport 3-1448

DUCK EMBRYO RABIES VACCINE

DUCK embryo rabies vaccine may be obtained through the individuals listed above, or through the biological distributing stations listed below:

Atlantic City: Board of Health, Municipal Building, ATlantic City 344-2121.

Asbury Park: Board of Health, Asbury Avenue and Main Street, PRospect 5-0196 (reg. hrs.); PRospect 4-7137 (after hours).

Bloomfield: Board of Health, Municipal Building, PIlgrim 3-4400 or PIlgrim 8-0500.

Camden: Department of Health, Municipal Building, WOodlawn 4-9000.

East Orange: Board of Health, 143 New Street, ORange 5-5640.

Elizabeth: Board of Health, Municipal Building, ELizabeth 3-6000 (reg. hrs.); After hours: Mr. Connelley, FLanders 1-1644; Mr. Cleary, ELizabeth 5-0270.

Hackensack: Hackensack Hospital, HUbbard 7-4000.

Hackettstown: Mr. William Greenham, 103 Little Street, GArden 5-4443.

Haddonfield: State Health District, 89 Haddon Avenue, HAzel 9-7550.

Jersey City: Board of Health, B Floor, Surgical Building, Medical Center, HEnderson 2-3273.

Long Branch: Board of Health, Garfield Court, CApital 9-0867.

Morristown: Board of Health, 29 Ann Street, JEfferson 8-3707.

Newark: Board of Health, Plane and William Streets, MArket 4-6400; After hours: Martland Medical Center, MItchell 3-8800.

North Arlington: Board of Health, Municipal Building, WYman 1-4367 or WYman 1-1087.

Paterson: Board of Health, Mill and Passaic Streets, ARmory 8-2110; After hours: Mrs. Richmond, MUtual 4-0097.

Perth Amboy: Board of Health, 44 Market Street, VAlley 6-0290.

Plainfield: Board of Health, Municipal Building, PLainfield 6-0704.

Somerville: Somerset Hospital, RAndolph 5-4000.

State of New Jersey Department of Health

Air Pollution

Automobiles are a major source of air pollution ranking first among leading sources cited in the September 1961 issue of *Patterns of Disease*, a Parke, Davis & Company publication for the medical profession. In Los Angeles, automobiles released 965 tons per day of hydrocarbons, 250 tons of nitrogen oxides, 19 tons of sulfur dioxide, 6,850 tons of carbon monoxide, and 27 tons of aerosols. Ranking second as a source of air pollution are other modes of transportation.

"The level of organic air pollutants in urban areas is highest in the winter. In the Gulf South, however, the levels in the winter and fall are almost identical," according to *Patterns*.

"Diseases influenced by air pollution include emphysema, chronic bronchitis, and bronchogenic carcinoma." Among the pollutants in the air we breathe, which are health hazards, are sulfur dioxide and sulfuric acid, carbon monoxide, ozone, nitrogen dioxide, and certain hydrocarbons.

"Air pollution is responsible for physical damage ranging from disintegration of nylon stockings to the crumbling of marble in buildings. It has even been held responsible for white house paint turning black almost overnight. Smog has reduced visibility to such an extent that airplane service was suspended, ferry boats collided, and traffic accidents increased. Vegetation is stunted, and damage to crops may be so great that the entire farm enterprise may be lost." In monetary terms, *Patterns* cites an estimated annual cost of $2,000,000,000 because of the air pollution for such household expenses as laundry, cleaning, redecorating, and replacement, and for such industrial expenses as structural maintenance, property deterioration, artificial lighting, and air filtering equipment.

Walter Redisch, M.D.
New York, N. Y.

Medical Management of Peripheral Vascular Disease*

Woolen socks, wide shoes, and whiskey are the traditional treatment triad for peripheral vascular disease. As Dr. Redisch shows here, there is much more to it than that.

Listed below is the traditional "routine" for the medical management of so-called "peripheral vascular disease." While these principles are still valid and (in obliterative peripheral arterial disease) very helpful, certain recent advances have widened our scope.

TABLE 1.

"VASCULAR ROUTINE"

1. Keep extremities dry and warm.
2. Avoid injuries. If such occur, report immediately to the doctor.
3. Use wide, firm shoes, allowing for as many pairs of woolen socks as necessary.
4. Do not smoke.
5. Take three ounces of Scotch, Bourbon or Brandy.
6. Reflex vasodilation by body warming, once or twice one hour every day.
7. Graded exercise (walking on even plane)
   or
8. Buerger's exercises.
9. Saunder's vasooscillating bed.

Two facts long known to some of us have found more widespread recognition recently:

1. That so-called peripheral vascular disease represents merely the peripheral manifestations of generalized vascular disease; and

2. That it is more rational to think in terms of disturbances of peripheral blood flow rather than in terms of peripheral vascular disease. To understand this Table 2 and Table 3 will help.

TABLE 2.

KNOWN MECHANISMS REGULATING PERIPHERAL CIRCULATION

1. Neurogenic
   a. Cerebrospinal
   b. Autonomic
2. Humeral
3. Metabolic

Table 2 is self-explanatory. Any disturbance in one of these regulatory mechanisms will cause a disturbance in blood flow, more often in the presence than in the absence of structural vessel disease.

TABLE 3.

CONDITIONS CAPABLE OF PRODUCING PERIPHERAL CIRCULATORY INSUFFICIENCY IN THE ABSENCE OF INTRINSIC PERIPHERAL VASCULAR DISEASE

1. Myocardial failure
2. Mitral stenosis with small left ventricle
3. Dehydration
4. Arterial hypotension
5. Shock
6. Coarctation of the aorta
7. Ball-valve thrombus in the left atrium
8. Aortic stenosis
9. Anemia and other hematologic disorders

*Presented May 17, 1961 at the 195th Annual Meeting of The Medical Society of New Jersey, Atlantic City. This work is from the New York University School of Medicine.

Table 3 lists conditions which may cause full-blown peripheral circulatory insufficiency in the absence of intrinsic vascular disease. Hence a division in "organic" and "functional" peripheral vascular disease can no longer be accepted.

Peripheral manifestations of vascular disease may be didactically divided into three types: those concerning the arterial, the venous or the minute segment of the vascular tree. However, it is necessary to keep in mind two compatible facts, one anatomic-physiologic and one clinical: we know since the anatomic investigations of Quiring,[1] followed by the splendid work of Saunders[2] with the x-ray microscope, that the development of the vascular tree is not simply a branching off from a central tube, but that from a diffuse capillary rete form the various vascular beds, multiple in *anlage* and growing into distinct functional units. Clinically, more often than not, two or all the three segments of the vascular tree are involved in a case. Spontaneous compensation of circulatory insufficiency then takes place by way of the above mentioned multiple *anlage,* which supplies "collateral circulation." Keeping this in mind, I shall discuss separately the management of arterial, venous and minute circulatory disturbances.

Table 4 shows the basic possibilities in dealing with *peripheral arterial disease.* Recent advances in vascular surgery have made it possible to state, that our first choice is the restoration of primary or mainline circulation wherever feasible. Spontaneous recanalization of an arterial thrombus or embolus is slow and rarely (if ever) leads to restoration of mainline flow. If the diagnosis of systemic embolus can be clearly established (*e.g.* in sudden occlusion of the aorta or an extremity artery in a patient with heart disease with or even without atrial fibrillation and in the absence of other manifestations of arterial disease) surgical intervention is mandatory. The diagnosis should be verified by aortography or arteriography, wherever justified doubt exists; and the operation performed at the earliest possible time. However, in my experience, removal of the embolus and secondary thrombus has been successful even if there has been undue procrastination for days. In arterial thrombus, evaluation by the medical-surgical vascular team based on clinical appraisal, visualization and flow measurements is desirable. In our experience 10 to 15 per cent of the cases seen are amenable to restorative surgery. The overwhelming majority has still to be handled medically.

In addition to the traditional "vascular routine" of Table 1 the following considerations are mandatory: while it is not yet possible to talk of etiology of occlusive peripheral arterial disease in the strict sense of the word, it is usually possible to determine the underlying vascular disease associated with it. About 90 per cent of all cases are atheromatous. In these, the presence or absence of diabetes mellitus is of great importance, because of the tendency in diabetics to small artery occlusion, to secondary infection and to frequent combination with minute vessel disease. Isolated small artery occlusions frequently call for the use of local surgery, in addition to specific measures to enhance collateral circulation. The remaining 10 per cent of cases with arterial occlusive disease represent one or the other form of angiitis, meaning an in-

1. Quiring, D. P.: Collateral Circulation, Philadelphia, Lea and Febiger, 1949.

2. Redisch, W., Tangco, F. F. and Saunders, R.: Peripheral Circulation in Health and Disease. New York, Grune and Stratton, 1957.

TABLE 4.

IMPROVEMENT OF ARTERIAL BLOOD SUPPLY

Restoration of Primary Circulation	Development of Collateral Circulation
1. *Spontaneous* (canalization of thrombus)	1. *Spontaneous*
2. *Surgical* (operative procedures)	2. *Medical* (interference with vasoconstrictor impulses)
3. *Medical* (relief of arterial spasm)	3. *Surgical* (sympathectomy)

flammatory process in the vessel wall. It is not within our scope here to enter the old [3] and recently revived [4] argument about so-called Buerger's disease. Suffice it to say that within the mentioned 10 per cent of cases, a rare instance may be encountered [5] filling the old clinical criteria for the diagnosis "thromboangiitis obliterans." Other cases are various forms of endangiitis such as Takayasu's disease,[6] or panangiitis such as polyarteritis nodosa. The association with the connective tissue (or collagen) group of diseases, the resemblance to sensitivity angiitis occurring in drug responses, the extremely frequent combination with minute vessel disease, all that puts these cases into the large group of immunologic disease.

The significance of almost all measures of the accepted "vascular routine," (Table 1) consists in shielding the body from vasoconstrictor impulses coming from the external environment. Reflex dilation by heat and graded exercise are the only exceptions. Drugs of the dibenamine group have added the possibility of shielding against vasoconstrictor impulses coming from the internal environment by inhibiting the action of catechol-amines, notably nor-epinephrine which is the physiologic peripheral vasoconstrictor in man. These drugs do not alter vessel wall responses. This is the prime reason we prefer dibenzylchlorethylamine or dibenzazapine to surgical sympathectomy which causes release of vasomotor tone, but sensitizes the vessel wall to the action of catechol-amines. On the other hand, the adrenergic blocking agents mentioned may produce side-effects due to their adrenolytic action. Chronic bronchospastic disease is an absolute contraindication to their use; tachycardia, enhancement of anginal syndrome and occasionally hypotension must be carefully watched for. By and large, the side-effects prohibit the drugs in about 20 per cent of the cases where their use appears clearly indicated. Other drugs, chemically related to epinephrine, are indicated in the management of intermittent claudication in the absence of trophic changes in the skin. They have been shown to enhance blood flow to the working skeletal muscle. Nylidrine and isoxsuprine belong in this group. The physician should, however, be alert for signs of irritability of the myocardium such as ventricular premature contractions. Postural measures to increase hydrostatic pressure proximally to the occluded vessels (such as elevation of the head of the bed in obliterative arterial disease of the lower extremities) may be of some help; caution, however, is necessary in the presence of tendency to edema, since edema in turn much aggravates occlusive arterial disease.

To forbid smoking is a time-honored measure in obliterative peripheral arterial disease. Recently, we have gathered some information, which may explain why some patients are obviously harmed by smoking, while in others it does not seem to influence the course of their vascular disease.

Table 5 shows the significant correlation between skin sensitivity to tobacco extracts and effects of tobacco smoking on skin blood flow. Investigation is being continued to find a possible correlation to "immunologic" vascular disease.

The wisdom of using anticoagulants in peripheral arterial obliterative disease has remained highly debatable. Much more careful

3. Wessler, S., Ming, S. C., Gurewich, V. and Freiman, S. G.: New England Journal of Medicine, 262:1149 (1960).

4. Wessler, S.: *Circulation*, 23:165 (1961).

5. v. Winiwarter, F.: Arkives Klinische Chirurgie, 23:202 (1879).

6. Ross, R. S. and McKusick, V. A.: Archives of Internal Medicine, 92:701 (1953).

TABLE 5.

		SKIN FLOW			MUSCLE FLOW		
		Decrease	No Change	Increase	Decrease	No Change	Increase
Total allergic	9	8	1	0	2	3	4
No OAS	8	7	1	0	2	2	4
OAS	1	1	0	0	0	1	0

TABLE 6.

DISTURBANCES IN PERIPHERAL CIRCULATION

Underlying Conditions and Their Management

Condition	Management
Atherosclerosis	Keep body weight 10 per cent below standard Restrict fat intake Encourage graded exercise Long term anticoagulation (?)
Diabetes mellitus	Control diabetes Avoid "ups and downs"
"Collagen" diseases	Corticosteroids Antimalarial drugs (?)
Luetic endarteritis	Penicillin
Tuberculous arteritis	Streptomycin-Isoniacin-PAS
Toxic endarteritis (*e.g.* ergot)	Discontinuation of noxe

and extensive investigative work is needed before conclusions are possible. Fibrinolytic agents are still in the experimental stage; they seem to hold real prospects for the future.

Table 6 summarizes the conditions most important in the association with peripheral circulatory disturbances. Their management is briefly outlined.

The treatment of ischemic ulcers and local gangrene should be dominated by the desire of saving as much of a limb as feasible without jeopardizing the general condition of the patient. The replacement of surgical debridement by the use of enzymes (streptokinase-streptodornase in the form of Varidase®-soaks or-jelly, papaya-enzyme in the form of Panafilcream® or fibrinolysin with desoxyribonucleic acid in the form of Elase-ointment®) has proved helpful, especially when used in combination with adrenergic blocking agents; in about 40 per cent of the cases it has been possible to avoid surgery or to reduce the necessary procedure to minor local resections instead of major amputations. The use of antibiotics to combat secondary local infection should be judicious, keeping in mind the fungus growth - promoting side-effect.

Peripheral venous disease: Disease of the superficial venous drainage system (generally referred to as "varicose veins") does not call for medical attention other than elevation of foot of bed and the use of elastic support. All further measures, if necessary at all, are surgical.

Thrombosis: The approach to the most important derangement in deep venous circulation, thrombosis, has changed since the popularization of anticoagulant drug therapy. Our first choice in thromboembolic disease nowadays is anticoagulation, because, basically this is not a local affair. Venous ligation on one limb is in a high proportion of cases followed by thrombosis in the contralateral extremity. Indications for deep venous ligation are practically identical with the contraindications to the use of anticogulants. These are listed in Table 7.

TABLE 7.

CONTRAINDICATIONS TO THE USE OF ANTICOAGULANTS

1. All hemorrhagic states and blood dyscrasias
2. History of bleeding
3. Advanced liver disease
4. Ulcerations in the G. I. tract
5. Very advanced Bright's disease
6. Behavioral difficulties (chronic alcoholism and the like)

As for the choice of anticoagulant, we usually start with heparin† and give a coumarin-type oral anticoagulant simultaneously where the situation permits, until satisfactory prothrombin consumption levels permit the discontinuation of heparin. The oral anticoagulant is continued for at least 2 to 3 weeks after acute symptoms have subsided. Under certain circumstances (*e.g.* in recurrent thrombophlebitis) long term anticoagulation should be maintained. Discontinuation of anticoagulant therapy should always be gradual, since sudden increase in coagulability of the blood may enhance embolization.

The postphlebitic syndrome is best managed by permanent elevation of the foot of the bed and use of elastic supports. If there are any signs of recurrent phlebitic activity, long term anticoagulation may be considered.

Minute vessel disease: Of the capillary telangiectasias, several are of diagnostic, but only one of medical-therapeutic interest: Rendu-Osler's disease, livoid, hemorrhagic hereditary telangiectasia frequently leads to blood loss anemia, which may be severe. Local surgery and cauterization may be necessary in addition to systemic antianemic treatment.

Among small vessel tumors, the so-called glomus tumors are of special interest. They arise from those capillary-smooth muscle-nerve fiber structures called *glomi* (which are fine-responding arterio-venous shunts in the fingers and toes) which may well be called the thermostats of the body. The tumors are tiny but as a rule call for amputation of the end phalanx, because they are extremely painful and may become malignant.

Exanthemata and enanthemata are part of certain infectious diseases and expressions of sensitivity manifestations.

Thermal injuries affect mostly the minute circulation. In frost-bite and trench foot, rewarming should be gradual and under good protection. The chronic states are regulatory disturbances, responding best to exercise, contrast baths and nicotinic acid in one form or the other. In contrast, erythromelalgia or vasodilator disorders of small vessels respond to aspirin, cooling and in some cases to histamine desensitization.

Systemic small vessel disease is almost invariably a manifestation of some underlying condition especially the various connective tissue (or collagen) disorders. Wherever corticosteroids or antimalarial drugs are indicated, they may also influence the vascular component. Of special interest in this respect is Raynaud's *disease* which is so frequent in early scleroderma that it is often difficult to separate the two conditions.

Raynaud's *phenomenon* in contrast, *per se*, is not a vascular disease, but a regulatory disorder due to hypersensitivity to cold or more often, to emotional stimuli. Mild forms (such as "dead fingers") do not require treatment. If annoying, adrenergic blocking agents, paravertebral block, and (eventually, in rare instances) sympathectomy may be employed.

Another type of purely regulatory disorder related to peripheral circulation is causalgia. Reflex dystrophy of an extremity, always associated with causalgia, may follow peripheral nerve injury. However, it occurs after myocardial infarction and in old rheumatic heart disease. It may be related to disuse, but is obviously triggered by dysfunction of the sympathetic innervation. Prevention by avoiding disuse and treatment with paravertebral blocks is advisable. In many of these regulatory disturbances, psychotherapy and pharmacologic treatment are indicated, at least as long as we do not know their physiologic substrates.

Extravascular conditions causing circulatory disturbances and the management of these extravascular conditions are briefly listed in Table 8.

Here are two examples showing the importance of the recognition and treatment of the underlying cause: The peculiar shallow, not infrequent leg ulcers in sickle cell anemia defy all local or systemic "vascular" treatment but respond as a rule promptly to blood transfusions. The thrombotic phenomena so frequent in polycythemia vera are not amenable to anticoagulation, but will subside only after proper treatment of the basic disease.

†Intravenously or subcutaneously.

The lymphatic system is usually treated as a stepchild, though it drains into the venous system and is, in more than one way, part of the peripheral circulation. Medical management of chronic lymphatic edema, especially after glandular resections, is tedious and slow in effect, but sometimes quite rewarding, especially if started early in the game and continued vigorously. It consists in daily "milking" of the limb, using a roll and pulley arrangement and various sleeves. Treatment of Milroy's disease and other forms of elephantiasis on the other hand is entirely surgical, if attempted at all.

TABLE 8.

DISTURBANCES IN PERIPHERAL CIRCULATION

Related Extravascular Conditions and Their Management

Condition	Management
CNS - Lesions	Papaverin Long term anticoagulation Cervical sympathectomy (?)
Heart disease	Keep out of failure Long term anticoagulation Cardiac surgery Treatment of SBE and rheumatic fever
Blood dyscrasias	
1. Anemias	Transfusions Specific therapy according to type 1. Pernicious An.—Liver, B_{12} 2. Gravidity An.—Folic Acid 3. Sec. (hypochromic) An.—Iron 4. Hemolytic An.—Corticosteroids
2. Leukemias	Transfusions Irradiation Specific drugs according to type 1. Acute L.—Folic Acid Antagonist, Nitrogen Mustard, TEM 2. Chronic lymphatic L.—Mercaptens, Nitrogen Mustard, p^{32} 3. Chronic myeloic L.—Myleran
3. Thrombocytopenic purpura	Splenectomy
4. Polycythemia	Repeated venesections p^{32}
5. Intra-abdominal malignancies	Surgery or irradiation

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Donald R. Reisfield, M.D.

New Brunswick

Varicosities in Veins of the Inguinal Canal During Pregnancy*

An inguinal mass during pregnancy does not always mean hernia. It may point to varicose veins in the inguinal canal—requiring very different management.

This is the report of an unusual complication of pregnancy: varicose veins of the inguinal canal presenting as a mass at the external inguinal ring. The clinical course and management of this varicosity is discussed, as is the importance of distinguishing it from inguinal hernia.

A 25-year old gravida-3, expected date of confinement October 12, 1960, was first seen on March 11, 1960. She had been an adopted child and no information was obtainable regarding the familial occurrence of varicosities.

Right leg greater saphenous varicosities were first noted in 1949 at the age of 14. In 1958, during the last half of her first pregnancy, further leg varicosities appeared. During the fifth month of that gestation a bulging mass was noted in the left inguinal area. A surgical consultatant said this was an inguinal hernia. The recommended surgery was not carried out and the mass spontaneously disappeared postpartum.

In 1959, curettage was done at 8 weeks for an incomplete abortion. There was no increase in the size of the right leg varicosities which had remained following the first pregnancy. The inguinal mass did not re-appear.

On the initial visit, in the second month of this gestation, the significant physical findings were: a symmetrically enlarged uterus appropriate to the patient's last menstrual date, a clinically gynecoid pelvis, beginning varicosities of the right calf region, irregular distention of the right greater saphenous vein, and in the left inguinal region a bulging 3 by 3 centimeter mass. Routine laboratory data were normal. Obstetrically her course was uneventful.

Varicosities in the right leg increased in size from the first visit. On May 19, vulvar varicosities were first noted. The inguinal region now exhibited bilateral masses, the left larger than the right side. The greatest discomfort was in the vulvar region where a "dragging" and aching sensation was present. Relief was obtained by perineal compression. Treatment of the leg varicosities consisted of elastic stockings to the mid-thigh applied immediately on arising, elevation of the foot of the patient's bed on five-inch blocks, and avoidance of prolonged standing. Four weeks later, inspection of the now prominently bulging inguinal regions revealed dilated superficial veins. Various manipulations were done bilaterally, including stethoscope auscultation, and occlusion of the venous system and inguinal canals in the erect and supine positions. These revealed slow, steady distention concomitant with filling in the varicosities of the



Fig. 1. Ninth month of gestation. Mass presenting in left inguinal region.

*From the Department of Obstetrics and Gynecology, Middlesex Hospital, New Brunswick, N. J.

lower extremities. Consequently, it was concluded that we were dealing not with inguinal hernia, but rather with bilateral varicosities of the veins of the round ligament and inguinal canal. (Figure 1) Compression of these round ligament varicosities by means of a maternity garment was advised, and relief from the dull dragging pain which these varicosities had produced was obtained.

Both legs were now severely involved with varicosities. The lower right leg contained small superficial bluish clusters which have been described [3] as the type specific veins of pregnancy or "angiectids."

The leg, vulvar and round ligament veins increased in size until the ninth month of gestation when stabilization was achieved.

Delivery was effected on October 16 by low forceps over a median episiotomy with caudal anesthesia following a total labor of two hours and 38 minutes. There was no excess bleeding from the episiotomy site as a result of the vulvar varicosities.

Twenty-four hours after delivery the round ligament varicosities had disappeared, as had the vulvar varicosities. The persisting leg varicosities included calf discoloration without palpable varicosities on the left, and palpable varicosities and distention along the course of the greater saphenous vein on the right. (Figure 2) Pelvic examination revealed no evidence of hematoma formation in the broad ligaments or in the retroperitoneal area.



Fig. 2. Twenty-four hours postpartum. Complete absence of mass or bulging in the inguinal regions.

Six weeks postpartum no varicosities or discoloration could be noted in the left leg. The right leg showed superficial discoloration in the calf region, and the greater saphenous was distended in the region of the lower thigh.

A search of the English language literature reveals only two papers where varicosities of this type are reported.

Dodd and Wright [2] reported an occasional case with inguinal venous swelling associated with discomfort while walking and sitting in a large series of pregnant patients followed for leg varicosities. An analogy to varicocele of the spermatic veins in the male was drawn. The treatment recommended when severe distress supervened was exploration of the saphenofemoral junction followed by excision of the round ligament.

Hodgkinson and Kroll [4] reported five patients with dilated veins of the inguinal canal and round ligament. Infra-red photography showed severe associated saphenous varicosities always maximal on the side of the inguinal protrusion. They felt that these veins were related to the ovarian system. However, their finding of the inguinal mass always on the side of maximal saphenous dilation would seem to indicate a relationship to this latter system. They cited the development of a large retroperitoneal hematoma following a normal spontaneous delivery in one of their patients as a further indication of distention in the ovarian system. In the case presented here the initial and larger inguinal mass was on the left side *opposite* to the side of the greatest saphenous distortion. Therefore, a relationship to the ovarian system would be supported. There was no evidence in our case of hematoma formation. An awareness of the possibility of occurrence of this complication should be maintained.

Two additional patients of Hodgkinson and Kroll [4] had an inguinal hernia (the most common condition which requires differentiation), and in both disappearance of the inguinal mass occurred between the twentieth and twenty-fourth week of gestation. Re-appearance occurred postpartum upon ambulation. This significant behavior of inguinal hernia clinically contrasts with that of inguinal venous distention which increases progressively during pregnancy, and is absent between gestations.

Barnofsky *et al.*[1] confirm the fact that hernias often disappear during pregnancy as the

enlarging uterus pushes the contents of the hernial sac away from the inguinal ring.

In the present case complete disappearance of the round ligament varicosities within 24 hours of delivery, and control of symptoms during pregnancy by means of simple compression would seem to confirm the conclusion that surgery was unwarranted. Surgery, of course, is definitely contra-indicated if the operation is advised under the misconception that one is dealing with an inguinal hernia. Inguinal hernia during pregnancy[1] probably requires only expectant observation with repair done following delivery.[4] However, if herniorrhaphy is performed during pregnancy the surgeon should be cognizant of this and the possibility of round ligament varicosities should be definitely ruled out before surgery is undertaken.

SUMMARY

1. A case manifesting the rare complication of varicosities of the inguinal canal veins during pregnancy is presented.

2. This should be differentiated from inguinal hernia. The appearance and progression of round ligament varicosities concomitant with pregnancy is contrasted to the frequent disappearance of inguinal hernia during a gestation.

3. The conservative management of this type of varicosity is stressed.

145 Livingston Avenue

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The Bureaucratic Superstate?

The Kefauver-Celler Bill poses a real and present danger to the area of freedom for American business and for Americans. If this bill becomes a model, then no area of American life is free from the threat of increasing central control, increasing bureaucratic conformity, and decreasing individual freedom. The American medical profession is also under attack. We are asked to believe that the only way to provide our senior citizens with adequate medical care is by compulsory payroll taxes on all wage-earners, by compulsory programs of insurance, by compulsory participation in one massive, rigid, government-controlled scheme . . . What sense does such a proposal make? It makes no good sense at all, except in an America that has given up its heritage of freedom and joined the dull, drab ranks of the bureaucratic superstate.—Richard M. Nixon to Pharmaceutical Advertising Club.

Otto Brandman, M.D.

Maplewood

Polythiazide: A New Oral Diuretic*

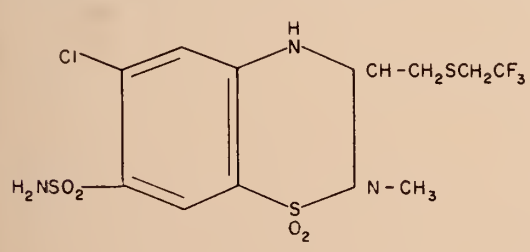
(A Preliminary Report)

Preliminary studies indicate that polythiazide is a safe and effective oral diuretic.

The elucidation of the mechanism of action of carbonic anhydrase effects by Pitts [1] in 1946, and the therapeutic application of carbonic anhydrase inhibition in the treatment of congestive heart failure by Schwartz in 1949, opened a field in which to seek highly effective oral diuretics.

The next giant step was taken by introduction of the chlorothiazide group.[2,3] It revolutionized the management of heart failure and reduced the use of injectible mercurials to a minimum. Since then, several analogues [4] of the benzothiadiazine series have been made available. But none of the diuretic agents in clinical use today have provided the necessary diuretic effects in all edema problems. Further evaluation of newer groups of agents is still actively pursued.

Recently, Dr. J. McManus of Pfizer Laboratories scrutinized other chlorothiazide derivatives and after extensive animal studies came up with a 2-methyl thiazide-polythiazide.* The structural formula follows. This proved to be a powerful diuretic in dogs and rats, of greater potency than any other available chlorothiazide, had a longer duration of action, and a more favorable sodium-potassium ratio.[5]



On the basis of these preliminary laboratory findings a clinical study was instituted. The first ten patients were studied in a ward under close clinical and laboratory observation. The following laboratory procedures were done initially and weekly thereafter during the patient's stay in the hospital, and monthly in the Out-patient department; blood sugar; alkaline phosphatase; thymol turbidity; cephalin flocculation; uric acid; serum sodium; serum potassium; serum chloride; blood urea nitrogen; and complete blood count. After these initial studies, which seemed to establish the relative safety and efficacy of polythiazide,* 38 ambulatory clinic patients under treatment for congestive failure were added to this investigation. All the ambulatory patients had previously been on oral diuretics, fortified in some

*We are indebted to James A. Garofalo, M.D., of Chas Pfizer & Co., Inc., Brooklyn, N. Y. for generous supplies of P-2525 (polythiazide). This work is from St. Michael's Hospital; and from the Cardiac Clinic, Board of Health, Newark, N. J.

1. Pitts, R. F. and Alexander, R. S.: American Journal of Physiology, 144:239 (1945).

2. Ford, R. V., Moyer, J. H. and Spur, C. L.: A.M.A. Archives of Int. Med., 100:582 (1958).

3. Beyer, K. H.: Annals of the New York Academy of Science, 71:363 (1958).

4. Ford, R. V.: Annals of the New York Academy of Science, 88:809 (1960).

5. Preliminary Pharmacological Evaluation of P-2525 and P-2530. Pfizer Laboratories. Sept. 1960. Personal communication.

by injections of mercurials for a long period of time. Polythiazide* was substituted in doses of 2 milligrams daily initially, and increased up to 6 milligrams daily. The dose which seemed to produce the most satisfactory clinical response, in edema state, varied from 2 milligrams to 4 milligrams daily.

RESULTS

THE ten hospitalized patients included three females. Ages ranged from 58 to 71. Five suffered from hypertensive heart disease and five from arteriosclerotic heart disease. All ten, prior to admission, were on oral diuretics augmented by injectible mercurials. After substitution of polythiazide* for the previously used oral diuretic, mercurials were discontinued in three patients; in six of the other patients the interval between mercurial injections was considerably lengthened; in one patient there was no essential change.

We felt it would be incorrect to attribute to the drug alone the results obtained in hospitalized patients; the usual hospital routine, bed-rest, low sodium diet (sodium was restricted to a Gram a day as rigorously as it is possible to do in a community institution), and a combination of mercurials with other oral diuretics might produce comparable results. More significant, however, seemed to be the results in 38 patients followed in the Outpatient department. This was a group of 21 females and 17 males, ranging in age from 48 to 68; 26 were hypertensives and 12 arteriosclerotics; all were in failure. In these patients, polythiazide* was substituted for the previously-used oral diuretic. The drug was well tolerated and in a few instances further loss of weight was noted. Average weight loss per patient after six months of therapy was four pounds. In this group, 14 patients were receiving injectible mercurials prior to initiation of polythiazide* therapy. It was possible to discontinue mercurials in four, and reduce the number of mercurial injections in eight by increasing the intervals between the injections considerably.

In the combined group of 48 patients, mercurials were discontinued completely in seven patients, and the interval between mercurial injections was increased in 14 patients. (Table 1)

TABLE 1.

MERCUHYDRIN REQUIREMENTS

		Mercuhydrin		
	Patients	Dis-continued	No. Inj. Reduced	No Change
Hospital	10	3	6	1
Ambulatory	38	4	8	26
Total	48	7	14	27

Overall improvement in comparison to previous therapy was noted in 27 patients; no change in 20; aggravation in one. All patients in the improved group lost weight during the period of observation despite the fact that they had previously received adequate doses of well-known diuretics. (Table 2)

TABLE 2.

EFFECTS OF SIX MONTHS OF POLYTHIAZIDE* THERAPY

Improved	27
No change	20
Worse	1
Total	48
Ratio improved	51%

Undesirable effects were noted in five patients; nausea in four, weakness in three, dizziness in two, metallic taste in two, and dryness of mouth in two. In no instance were the reactions severe enough to necessitate discontinuance of the drug. (Table 3)

Blood chemistry abnormalities: Uric acid elevation was noted in 39 patients; thymol turbidity in 21; blood sugar in two. Borderline depression of sodium and potassium levels was noted in several instances without any clinical symptomatology; hypokalemia could easily be corrected by dietary supplements of

TABLE 3.

POLYTHIAZIDE* SIDE EFFECTS

No undesirable effects	43 patients
Some side effects	5 patients
4 had nausea	
2 had dryness of mouth	
2 had "metallic taste"	
2 complained of dizziness	
3 complained of weakness	

Total reactions — 13

TABLE 4.

ABNORMALITIES IN BLOOD CHEMISTRIES

	Abnormalities in		
	Blood Sugar	Uric Acid	Thymol Turbidity
10 hospital In-patients	0	9	8
38 Ambulatory patients	2	30	13
48 Total patients	2	39	21

orange juice. In spite of the high percentage of patients with hyperuricemia, no clinical symptoms of gout were so far recorded. (Table 4)

The *hypotensive effect* of polythiazide* was not within the scope of this study; however, a generally moderate decrease in the systolic and diastolic ranges could be observed.

SUMMARY

1. A new oral diuretic—polythiazide*—has been administered over a period of six months to 48 patients.

2. On the basis of presented data, polythiazide* appears to be an effective and safe oral diuretic, comparing favorably with other oral diuretics in the same family group.

558 Prospect Street

Fine Print on Drug Labels

The Food and Drug Administration plans to do something about the frequent complaints concerning the "fine print" in drug labeling material.

Proposed regulations, issued last month, would require the printing of cautions, warnings, contra-indications, and side effects from prescription drugs in easily readable type of not less than 8-point. This is the size we use for case reports in this JOURNAL. The regulation would also apply to medical devices and veterinary drugs, as well as human medications. The proposed regulations specify that the required information: (a) be in reasonable type size and location as related to the type size and location of statements dealing with indications for use of the drug; (b) be in easily readable style of type of not less than 8-point size; and (c) be on a contrasting background.

If both sides of a brochure sheet are used, the printing on one side must not be visible from the other side, under the proposal.

The type size and readability requirement would not apply to a reprint of a medical journal article if the reprint is in the same size and style of type as that in which the article was originally published.

The Commissioner would have authority to allow a smaller type size if the use of 8-point type is impracticable and where alternative printing would be sufficiently readable to accomplish the intended purpose.

Trustees' Meeting: September 17, 1961

At its September 17, 1961 session, actions taken by the Board of Trustees included the following:

JOINT MSP-HSP RIDER

In August 1961, by mail ballot the Trustees had voted unanimously to accept the recommendation of the Executive Committee to give official approval to the joint MSP-HSP rider as proposed.

Action: The mail vote was ratified by *viva voce* vote at this session.

NATIONAL FOUNDATION

Received and noted was a communication from the National Foundation outlining current patient-aid policies which permit assistance to families of private as well as non-private patients without involvement in the traditional patient-physician relationship, and without concern in the matter of the physician's and surgeon's fee. The communication was sent in the hope that it would minimize misunderstanding about the non-payment of professional fees, inasmuch as chapters occasionally are billed by physicians for personal professional services in the care of patients with acute or residual paralytic poliomyelitis.

NEW JERSEY WELFARE COUNCIL

The Medical Society was invited to co-sponsor a session on "Home Care Programs—The Patient's Home as a Treatment Center" of the Council's annual conference on October 25, 1961. Other co-sponsors will be the New Jersey Division on Aging and the New Jersey Hospital Association. The program for the session was presented for review.

Action: The Board voted that the Medical Society co-sponsor the session, and that representatives to attend be appointed at the discretion of the President.

NEW JERSEY PUBLIC HEALTH ASSOCIATION

The Association banquet meeting, co-sponsored by the New Jersey Welfare Council, will be held on October 24, 1961, in Asbury Park. The program will be "Medical Care for the Aged," and Dr. McCall has been invited to participate from the standpoint of the AMA and the State Society, with Dr. J. Douglas, Brown, Dean of the Faculty of Princeton University, presenting a different point of view. Request was made to have Dr. McCall designated officially as the Society's representative.

Action: Dr. McCall was designated as our official representative at this meeting.

OSTEOPATHIC ASSOCIATION

The Executive Committee, as directed by the Board, met with representatives of the *New Jersey Osteopathic Medical Association* (a splinter group of the New Jersey Association of Osteopathic Physicians and Surgeons) on July 19, 1961. Purpose of the meeting was to explore the desires of this group. They were asked to clarify what they wanted and how the Medical Society could help them. Their primary goal was to achieve status that would permit them to avail themselves of the full privileges inherent in their licenses as physicians and surgeons. They seek free access to hospitals and free association with doctors of medicine as consultants. Secondarily, they were interested in obtaining a degree in medicine acceptable to the Society as a means of achieving their objectives through membership in the Society.

Since the release of the opinion (August 3, 1961) that members of the Medical Society are now ethically at liberty to work with any and all fully licensed physicians and surgeons of New Jersey in the care of patients, in or out of hospitals, their primary objective has been met without membership in this Society. No further word has been received from the New Jersey Osteopathic Medical Association.

The Executive Committee also met with representatives of the *New Jersey Association of Osteopathic Physicians and Surgeons*. This was in response to their request. The meeting took place on August 17, 1961. The Osteopathic Association asked:

(1) To what extent is The Medical Society of New Jersey in position to assist in carrying out the changes—(those flowing from the new opinion of the Judicial Council)?

(2) Will the Medical Society help in making postgraduate education available to doctors of osteopathy?

In response to number 1, the committee pointed out that the Society had already rendered vital assistance to the new relationship, that the new position had been called to the attention of the N. J. Hospital Association, that that Association had informed its member-hospitals, that the Society cannot and does not influence local hospitals to add individual doctors of medicine to their staffs, and that the decision as to who shall receive staff appointments is exclusive to the individual hospital.

In discussing question number 2, the Committee pointed out that our Society had influence over its own members only: that it cannot exercise influence over outside agencies.

The Society has dissolved the separating professional barriers between members of the Society and other licensed physicians and surgeons in New Jersey. It is prepared, in this spirit, to confer with and advise members of the Osteopathic Association in any way consonant with this new position and its proper limitations. The Association representatives asked if, to further this cooperation, the Medical Society would establish a liaison committee with their Association.

The members of the Executive Committee favored establishment of such a liaison committee.

Action: The Board agreed to authorize such a committee; directed that it be established with the same Medical Society personnel as the liaison committees with other professional organizations. The Association representatives had been informed of the Society's liaison committee composition, and had agreed to arrange their committee along similar lines.

Dr. Buchanan reported that subsequent to the meeting he had received a letter from the President of the Osteopathic Association requesting that our Society recognize only the New Jersey Association of Osteopathic Physicians and Surgeons and have liaison only with that Association.

Action: The Board considered that the creation of this liaison committee will answer this request.

AMA INSTITUTE

In accordance with authorization from the Board given on August 1, 1961, President Buchanan designated Dr. Wegryn and Mr. Nevin to attend the AMA Institute and the meeting of Medical Society Executives in Chicago.

MEDICAL HOSPITAL LIAISON COMMITTEE

The Liaison Committee met on July 26, 1961. The Hospital Association representatives presented the following items:

1. The Association favors both A-10 and A-669 (both dealing with welfare assistance programs). Though it would prefer A-10, it has concluded that A-669 has a chance of passing but A-10 has not. Accordingly, the Association has committed its support to A-669.
   (The Medical Society has approved A-10 and disapproved A-669.)
2. The Association is interested in the Society's newly established Special Committee on Nursing Education and Recruitment, and is eager to cooperate. The Association has a similar committee.
3. The Association is willing to cooperate with the Society in any effort to reduce the paper work that must be done by physicians in the processing of insurance claims and reports.

The following item was presented by the Society's representatives:

Decision of the State Board of Medical Examiners to seek extension of the term of exemption (from the prohibitions of the Medical Practice Act) of members of resident medical staffs of approved hospitals from the present maximum of 2 years to a new maximum of 5 years.

Action: Both parent organizations are asked to write the Attorney General urging the immediate introduction of this amendment as an administrative measure and pledging full support of it.

Also discussed with hospital representatives was the new opinion which eliminates the ethical ban on voluntary association between doctors of medicine and fully licensed doctors of osteopathy. Its probable consequences upon staff appointments in New Jersey hospitals was estimated. The Hospital Association representatives received the opinion favorably and indicated their willingness to assist in bringing to satisfactory solutions the problems of hospital staff appointments which it will probably precipitate.

MEDICAL-LEGAL TESTIMONY

A communication from Mr. McConnell, Administrative Director of the Courts, advised that on July 27, 1961, the Supreme Court

adopted Rule 4:25A—*Impartial Medical Examinations and Expert Testimony*—to be effective with the opening of the new term of court on September 11, 1961. The Rule will be applicable to actions instituted in the Superior and County Courts in Essex, Morris, Union, and Warren Counties, to recover damages for personal injuries or wrongful death when the nature, extent, or cause of injuries or the cause of death are in dispute. The Administrative Director of the Courts will maintain a panel of impartial medical experts. The specialties to be represented on the panel and the number of experts in each specialty will be determined jointly by The Medical Society of New Jersey and an advisory committee appointed by the Supreme Court. The experts to serve on the panel in the several specialties will be designated by The Medical Society of New Jersey.

The Chief Justice of our Supreme Court has urged that the panel be completed at the earliest possible date "since we are anxious to avoid delays in the institution of the program." To carry through this three-year pilot experiment in the four counties which compose the first district within The Medical Society of New Jersey, a list of eighteen specialties was submitted by the court's committee.

Action: The Board directed that the president of each of the four component societies concerned—Essex, Morris, Union, and Warren—be requested to submit the names of at least three qualified nominees, as far as possible, in each of the eighteen categories specified, for subsequent appointment at a state level. Dr. Greifinger emphasized that nominees should *not* be physician-members who, by the nature of their practice (such as compensation work), are frequently appearing in court.

The Board agreed that the Special Committee on Medical-Legal Testimony (whose reappointment was withheld at the beginning of the administrative year pending further developments in this matter) be reappointed as of this date.

The Special Committee on Medical-Legal Testimony was directed to obtain a list of nominees from the four component societies, to submit the lists with its recommendations for appointment of the panel members to the Executive Committee. The Executive Committee was authorized to appoint the panel members and submit the list of appointees to the Supreme Court Committee.

COUNCIL ON PUBLIC RELATIONS

The following recommendations of the Council on Public Relations, taken at its meeting July 23, 1961, were submitted to the Board for its consideration and action:

Attendance at Meetings: The council unanimously recommends the desirability of amending the appropriate section of the Society's Bylaws to include the following:

> If a member of a council or committee—either appointed by the President or elected by the House of Delegates—absents himself from two consecutive meetings without excuse, he shall be presumed to have vacated his position on the council or committee, and the President shall fill the vacancy pro tem.

Action: The recommendation is approved and forwarded to the Committee on Revision of Constitution and Bylaws for implementation.

Membership News Letter: The council unanimously recommends that the following procedure be initiated:

Each year component medical societies receive a compilation of *Membership News Letters* in bound form and indexed for ready reference, for retention in the official files of the county societies.

Action: The recommendation was approved.

CONSTITUTION AND BYLAWS

The council unanimously recommends that the following procedure also be initiated:

> The Constitution and Bylaws of The Medical Society of New Jersey as it emerges from the House of Delegates for the ensuing year be published in THE JOURNAL annually.

In discussion it was pointed out that amendments to the Constitution and Bylaws are published annually in the *Transactions* issue of THE JOURNAL (July), and that copies of the Constitution and Bylaws have been supplied to officers of component societies and state society council and committee chairmen together with revised pages annually in accordance with amendments, and that to publish the complete Constitution and Bylaws each year in THE JOURNAL would be costly.

Action: The recommendation was disapproved.

COMMITTEE ON TRAFFIC SAFETY

The following recommendations of the Special Committee on Traffic Safety, taken at its meeting August 2, 1961, were submitted to the Board for its consideration and action:

Physicians' Panel: (A) The special committee recommends that The Medical Society

of New Jersey cooperate with the Division of Motor Vehicles in its request to have qualified physicians pass upon findings of examinations to determine whether a suspected cardiac should drive.

(B) The special committee further recommends that the panel be obtained in this manner: Component societies be informed that the Division of Motor Vehicles is seeking this service from The Medical Society of New Jersey and be invited to compile a list of not more than three qualified practitioners to pass upon suspect cardiac conditions from candidates who offer themselves voluntarily for this role.

Action: These two recommendations were approved.

Use of Seat Belts: The committee recommends that The Medical Society of New Jersey support the encouragement and use of safety belts in motor vehicles.

Action: This recommendation of the special committee was approved.

Testimony in Drunken Driving Cases: The committee recommends that a memorandum on this be prepared by the Executive Officer for the *News Letter*. This should include relevant portions of the applicable statutes.

Action: This recommendation was approved.

HEALTH AND SAFETY OF WORKERS

Governor Meyner acknowledged receipt of the Board's recommendation that a physician be appointed to the Advisory Committee. The Governor forwarded a copy of the Board's letter to the Committee with the recommendation that consideration be given to the suggestion if the commitee elects to recommend a permanent rule-making board. He will give consideration to the request when he receives the final report from the Advisory Committee.

A follow-up letter from the Committee states: "the advice of your Society in the preparation of a suggested new law would be valuable and should be requested," and a fourth draft of the proposed act was enclosed.

Dr. Mulligan reported that inasmuch as the original Board action was the result of a suggestion from Dr. Caldwell (chairman of the Special Committee on Industrial Health) he referred the correspondence and fourth draft of the legislation to Dr. Caldwell for comment and recommendations.

Dr. Caldwell stated that the only recommendation from his committee was that Section 17 of the proposed legislation— establishing within the Department of Labor and Industry an "Industrial Safety Board" and outlining the membership of such board (paragraph 2)—be amended to include "and one member from a list of names submitted by The Medical Society of New Jersey."

Action: The recommendation of the special committee was approved. The secretary of the Advisory Committee will be so advised. A letter of appreciation will be sent to Governor Meyner acknowledging his interest in the Society's original recommendation and informing him of the subsequent recommendation being sent to the Advisory Committee.

S-150

A letter was read from Dr. Royal A. Schaaf which stated that the position of the Medical Society on S-150—*No Action*—is at complete variance from that of MSP which recorded its vigorous opposition to the measure—"In the opinion of the Board of Medical-Surgical Plan of New Jersey, S-150 is definitely *not* in the public interest and it should be actively opposed by The Medical Society of New Jersey. May I respectfully but urgently request that this be brought to the attention of the Trustees of The Medical Society of New Jersey at the earliest possible date."

The Board noted that two copies of the communication were supplied to the Executive Officer; and that a reply was sent by Mr. Nevin to Dr. Schaaf reporting the full discussion of the Council on Legislation regarding S-150, which concluded "that the door to further consideration of the measure is not closed, in view of the phrase '. . . the council recommended that *at this time* the official position of the Society be one of "no action".' "

Dr. Llyod stated that, as a member of the Board of Trustees of MSP, recently he had received a communication from the bio-analytic laboratories' legal counsel, supporting the Plan's position on S-150.

Action: With the Board's consent, the chairman directed that no action be taken on the communication at this time in view of the reply supplied to Dr. Schaaf by Mr. Nevin.

BEQUEST TO THE MEDICAL SOCIETY

Under the will of A. May VanDerveer, there was a bequest to The Medical Society of New Jersey of a portrait of Dr. Lawrence VanDerveer and all medical books in her possession at the time of her death; and all licenses to practice medicine which have no monetary value. (Dr. VanDerveer was the 12th President of The Medical Society of New Jersey in 1784.)

Two cartons of old books, dated in the late 1700's and early 1800's, and a portrait of Dr. VanDerveer in an old frame have been received.

Action: Dr. Rogers, the Society's Historian-Archivist, will be requested to evaluate the contents of the two cartons. The portrait of Dr. VanDerveer will be hung in a suitable place in the headquarters building.

AMA CLINICAL MEETING

Dr. Wegryn moved—seconded by Dr. Bedrick, and carried—that the President, President-Elect, Secretary, Executive Officer, and one alternate delegate be authorized to attend the AMA Clinical Meeting, Denver, November 26-30, with expenses paid in accordance with the budget allowance. Dr. Bowers was named as the alternate delegate to attend the meeting.

INSURANCE PROGRAM

Dr. Featherston, chairman of the Special Committee on Medical Defense and Insurance, reported that participation of new members in the several Society-sponsored insurance programs, particularly accident and health, comprehensive medical, and life—is limited to application within 90 days after election for the new member to qualify on a selective basis. Applications received after the 90-day limitation are on a selective basis. He suggested that a folder be prepared detailing the insurance program available to new members together with any other pertinent information. This could be provided by the component societies to new members immediately upon their election. The Blanksteen Agency is willing to assume the cost of printing materials on the three insurance programs it handles for the Society.

Frequently toward the end of a calendar year the component societies elect new members but do not report them with their appropriate assessment to the State Society until after the first of the following year. Some of the counties feel it is a financial burden on a new member to pay even a proration of the State assessment when elected toward the end of a calendar year because the new member will not receive membership benefits for more than a few months in the particular year. Therefore, the new member is billed and pays the membership assesment for the following calendar year, when he is then reported to the Executive Offices.

Dr. Greifinger pointed out that election to membership in a component society automatically makes the physician a member of the State Society, and that it is unconstitutional for a member to be accepted at county level without payment of the State Society assessment. He suggested that the Executive Offices communicate with the component societies and request that their constitutions and bylaws be amended to conform with the provision of the State Society Constitution and Bylaws, particularly as to the reporting and payment of the State Society assessment in order for a physician to be considered a member of a component society and of The Medical Society of New Jersey.

Action: Dr. Greifinger's suggestion was approved.

An Appreciation from the Health Commissioner

The State Department of Health expresses appreciation to The Medical Society of New Jersey and to physicians throughout the state, who participated in the National Cooperative Leukemia Study. This project was supported by a grant from the National Cancer Institute, as outlined in this JOURNAL in May 1959.

This study of leukemia and lymphoma in children was conducted by the Cancer Program of the State Department of Health and the Public Health Service from March 1959 to April 1961. The Public Health Service will compile the results of data from New Jersey and 13 other centers in the United States as an aid towards research in leukemia.

Proposed Amendment to the Constitution

The following proposed amendment to the Constitution was accepted by the House of Delegates at the 1961 Annual Meeting and will be presented for adoption at the meeting in May 1962. It is herewith published in compliance with the Constitutional provision to that effect:

ARTICLE IV — ORGANIZATION OF THE SOCIETY

Current

SECTION 4 — DELEGATES

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Proposed

SECTION 4 — DELEGATES

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each twenty (20) members or major fraction thereof, unless otherwise stipulated by the House of Delegates in the interest of maintaining the total membership of the House so that it does not exceed four hundred (400) members, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office for each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Pharmaceutical Industry Relationships*

by EUGENE N. BEESLEY, Indianapolis

A decade or two ago the average patient received his physician's prescription without question, accepting the fact that the meaning of those Latin hieroglyphics was none of his business. Today the doctor encounters self-educated therapists who have their own ideas regarding the medication they should take.

In this same period people also have moved in their thinking from an acceptance of certain limitations in man's ability to solve material problems to a feeling of confidence that nothing is impossible. Science, it seems, has given us a magic lamp which needs but a little rubbing to make miracles. And along with this, the public has been led to believe by proponents of government spending and government control that every miracle can be made to happen overnight.

It is human nature to believe gossip and criticism about a stranger more readily than about someone whose integrity and good works are well known. Until recent times the medical profession had little reason to be concerned with the operating problems of the pharmaceutical industry; and even today, as far as the general public is concerned, the industry is a complete stranger.

To avoid intrusion upon the relationship of the physician with his patient, ethical pharma-

*Abstracted from the May 1961 Journal of the Indiana State Medical Association. Mr. Beesley is President of Eli Lilly and Company, and an official of the American Pharmaceutical Manufacturers Association.

ceutical manufacturers have over the years shied away from communication with the general public. Thus, we have aggravated our present public relations problems.

It is now apparent that the press, public and government will allow no choice as to whether there is public communication about health matters. The possibility of keeping new developments in the field of cancer, heart disease or poliomyelitis off the front page is slight. A problem which the pharmaceutical industry faces is continuing its traditional role of working with the practicing physician on a high ethical and scientific plane and, at the same time, finding ways to communicate effectively with the public without intruding upon the physician-patient relationship.

The profusion of therapeutic advances resulting from success in scientific research has brought to the practicing physician the problem of how to keep up to date with the many significant new medicines.

Medical school and postgraduate education cannot provide all of the help. The time lag between laboratory discoveries and their practical application in the hands of the physician has been reduced by the pharmaceutical company salesman and the company's medical staff which stands behind him. Industry's promotion technics have benefited the medical profession and the general public. It must find a way to get a better understanding of its promotional efforts to people in government and in the communication field particularly.

The general public does not understand the economics of consumer product distribution in any field. This is especially true for pharmaceuticals and biologicals. The public does not appreciate the fact that, if adequate supplies of fresh stocks of medicines are to be available in every corner drug store and hospital across the land, the cost of fast and convenient distribution through professional channels must be met. I doubt that most people realize that about half of each dollar which they spend at the prescription counter goes for the handling of their medicine—*not* for the making of it.

When it comes to meeting criticism of "high" drug prices and "profiteering," the pharmaceutical manufacturer has self-imposed restraints upon his communications with the public. The consumer has no way of knowing what the manufacturer charges because fees for the pharmacist's services become a part of the total price which he pays for his medicine. This means that the manufacturer needs the support of those in the medical care field who have direct contact with the patient to help explain the price and value of drug products. The physician, the pharmacist and the manufacturer all have an important stake in satisfying the patient that he is getting his money's worth when he purchases medical care.

A sizable hazard on the obstacle course of medical care stems from the nature of politics and the desire of every politician to promote what is thought to be good because of its popularity. This makes free medicine, free medical care, free hospital services most appealing causes for elected representatives to support.

This will, no doubt always make investigations of the drug industry popular political pastimes.

Ethical pharmaceutical manufacturers have been castigated in some quarters for their emphasis on quality control in their manufacturing processes and for standing behind brand names for their products.

Our critics have said that the U. S. Pharmacopoeia and the Food and Drug Administration are all that the public needs to guarantee the potency, safety and purity of its medicines. But quality cannot be *inspected* into a product; it must be *built* into the product at every step of the manufacturing process. If federal inspection of drug products were ever to be the sole guarantee of their potency, safety and purity the FDA would need an inspector alongside every production operator and every control chemist in every drug manufacturing company in the country. Fortunately, the public is safeguarded by the reliability of the manufacturer and his willingness to stake his reputation upon the quality of his products.

It would be unforgivable to delude people into thinking that Big Government alone can protect the quality of their medicines any more than Big Government can give them "free" medical care.

We cannot, in good conscience, stand by and witness the undermining of basic principles and practices which have helped to advance medical care in this country. Responsible people in government, the professions, and all walks of life must be alerted to the dangers which confront our medical care system. They must be provided with information which will enable them to evaluate proposed remedies for its alleged shortcomings. They must satisfy themselves that something better is really available before relinquishing something which works much better than its critics will admit.

I doubt that taking medicine will ever be-

come popular or that the industry which makes medicine will ever win a popularity contest. I am optimistic enough, however, to believe that the pharmaceutical industry can make itself known for what it is and can fully earn the public's confidence and respect. I am hopeful that, for the most part, the industry has the confidence and respect of the medical profession and that it can continue to demonstrate that it merits both.

Dinner Dance

195th Annual Meeting

May 15, 1961

The speakers' section of the Dinner Dance convened at 9:10 p.m. in the Hotel Chalfonte, Mr. Richard I. Nevin, Toastmaster.

THE TOASTMASTER: Ladies and Gentlemen: Toward the end of the "Taming of the Shrew," when the tortured path of true love begins to run smooth, Shakespeare has one of the characters say:

> "At last, though long, our jarring notes agree:
> And time it is, when raging war is done,
> To Laugh at 'scapes and perils overblown."

In that mood, at the end of a very busy, sometimes hectic year in which as President he was deeply and continuously involved, Jesse McCall comes here tonight. In that mood we gather here tonight "to laugh at 'scapes and perils overblown," to recall with satisfaction the circumstances that the House finally adjourned in serenity and agreement, and to recognize with Jesse, as he foretold in his inaugural address, that the journey is done and the summit attained and the barriers fall and he, the far wanderer, is home again.

We turn from the democracy of deliberative action to the democracy of convivial fellowship. We are drawn here tonight by our friendly feeling for one another, our loyalty to The Medical Society of New Jersey and those who serve it well; but especially by our admiration and affection for one who, by competence, dependability and magnificent performance, has shown himself to be a true and splendid man and a true and outstanding leader. It is our pleasure tonight to render deserved and sincere tribute to President Jesse McCall and his vivacious and charming wife Louise. (Applause)

I'm not ordinarily so surrounded by papers, but I have all sorts of blueprints and directions, that even following my natural impulses I would first want to acquaint all of you with all of us who are at the head table in case you have any doubts as to who is who.

MRS. RALPH K. BUSH: Mr. Toastmaster, President and Mrs. McCall, Mrs. Mackersie, Dr. and Mrs. Allman, Honored Guests, Members and Guests of the Woman's Auxiliary and the Medical Society:

The Dinner-Dance honoring Dr. and Mrs. McCall is under the auspices of the Woman's Auxiliary. It is, therefore, my pleasure to welcome you and hope that the evening planned for your enjoyment is a pleasant one.

Dr. and Mrs. McCall have carried on their joint responsibility with dignity and have won the high respect of the Medical Society and the Auxiliary.

No one knows better than a retiring president the truth of the ageless quotation, "As ye give, so shall ye receive." Dr. McCall has given constantly of his time, energy and substance. But I am sure, now that the end of the road has been reached, the giving seems so little as compared to the many intangible gifts of friendship, the loyalty of members and associates—all of which have contributed to his accomplishments.

The year 1960-61 has been earmarked as one of harmonious cooperation between the Medical Society and its Auxiliary. We are members of its "team," dedicated to upholding the high standards of American medicine. The members of the Auxiliary contributed approximately $5,000 to the Medical Student Loan Fund, which is proof of our willingness to assist whenever called upon.

And so, for Dr. and Mrs. McCall, let us make this an occasion which will be a fitting climax to his year of service.

(Introduction of guests at head table)

THE TOASTMASTER: Now, if you will turn to your program, we have dealt with introductions and by now the party should be warming up. We come to presentations.

It is customary at this meeting every year that the immediate Past-President induct the President who is outgoing, extrovert, into the august and aristocratic fellowship of the Fellows of The Medical Society of New Jersey. So, as the immediate Past-President, I now call upon Dr. F. Clyde Bowers to make the presentation to Dr. McCall.

DR. F. CLYDE BOWERS: Thank you, Dick.

Mr. Toastmaster, Ladies and Gentlemen: This, I think, is a fairly easy task. I hope it is going to turn out that way, because I've known Jesse and Louise McCall for over a quarter of a century. During that period and particularly during the last few years I've come to know Jesse rather intimately. We have traveled over the country together and all over New Jersey. Therefore, I feel qualified to offer whatever accolades might be proper. I hesitate to do so because it may interfere with your dancing, and if you know Jesse McCall, he will answer me and that will take all night. (Laughter) And if you don't believe me, I would suggest sometime when you have three hours off that you ask him to tell you the story of the minnyball.

Now, Sam Sica and a few other boys and Jesse McCall and I went down to Washington a couple of years ago. From Trenton to Washington takes about three hours. Jesse started telling this story when we pulled out of the station and he never finished until we entered Union Station in Washington; and they gave us only one drink the entire distance, and I've never forgiven him for that. (Laughter)

Furthermore, if any of you were in the House of Delegates this afternoon you found that Jesse was having a little difficulty up on the platform because poor Mrs. Buchanan got lost somewhere; we don't know where. It was no fault of hers. She was just given the wrong steer; but it meant that Dick Nevin and I were in the back room wringing our hands hoping she'd show up, and poor Dick with his great Jesuit training was praying to Dear God that she'd get off that elevator. I was using the same words, but I'm afraid not with the same dignity. (Laughter)

However, Jesse, as is wont, rose to the occasion. I have never been a television performer before, but I learned something that means if you want something to keep on going you do this. (indicating) So I stood at the back of the room stretching, and poor Jesse is up there going on and on. So, if those of you who wondered why he didn't stick to the text this afternoon, that's one of the reasons. (Laughter) But I must say he did an excellent job.

I don't know how he ever came up from Virginia and invaded the sanctity of one of our smaller counties in the northern part of New Jersey. I don't know how he ever found it. But he got there, and I'm sure that a lot of those farmers up there never heard of a southerner much less a Virginian. But he was taken into their hearts and has stayed there ever since.

But just to show what kind of an interloper he is, he wasn't satisfied with conquering Sussex; he's invaded Morris, too, which is my county. (Laughter) And I'm sure that he has a better record of attendance at the annual meetings of the Morris County Medical Society than I have, and I think mine is pretty good. (Laughter)

But over it all, we all love Jesse McCall and I don't have to tell you what a wonderful job he has done. We certainly appreciate it.

And it is now my pleasure, on behalf of the Fellows of The Medical Society of New Jersey to present to you, Jesse McCall, this key which is emblematic of membership in this exclusive society. Welcome, Jesse. (Applause)

THE TOASTMASTER: Don't sit down, Dr. McCall. Fellow, it is now your turn to present the Fellowette's key to Mrs. Ralph Bush. The Fellowettes is the corresponding group in the Woman's Auxiliary to The Medical Society of New Jersey to our Fellows' Association.

DR. MCCALL: Marge is "See-Saw Marjorie Daw" to me.

I'm going to look to see if this is nicer than my own. (Laughter) It should be. I'm sure it will be received more graciously.

This is an additional privilege. It seems to me that for the last four days I have been talking about things of that type that have been accorded me. I hope I have convinced most of the members, and maybe all of them, of The Medical Society of New Jersey how sincerely interested I am in our interests and those of, well, even my own little Lynn who was—what did you say she was doing out there? Cutting a rug?—all our public.

I have earnestly through the years devoted a lot of time working and even hours that were supposed to be devoted to sleep to it. We have a gal alongside me here, however,

who with the same and even possibly a greater interest has devoted herself to the same project.

Sometime before I took office a year ago, Clyde Bowers said, "Well, now, you will have innumerable occasions when you will be associated and directly in contact with the President of the Auxiliary in your various visits across the state." As a matter of fact, through the year I've seen Marjorie Bush, I think, only twice at our official meetings. Now, that has been no fault of hers or mine. The first of those was fully ten months ago and at that time she had a schedule which I looked over and which I think involved, well, weeks here, there and yonder that had only one or two free days. We were supposed to be together, I believe, at a meeting in Monmouth County some weeks ago. The fog kept us away. She has followed, I'm sure, the same complete devotion to duty and interest in the welfare of the Auxiliary and, through the Auxiliary, to The Medical Society of New Jersey that I have tried to and which I'm sure all of you have.

It is somewhat of a small reward for all that service that we present her with this particular pin, this key, but I hope that it will remind her in various times when she has some leisure in the future, of the love, the respect, all the consideration that we hold for a devoted servant.

"See-saw Marjorie Daw," with our deep respect and devotion.

MRS. RALPH K. BUSH: Thank you very much.

TOASTMASTER: Every toastmaster dreams of finding some epic romantic means of summarizing what he has in mind as he introduces the guest of honor. By way of illustrating what I mean I find myself recalling a story that was told to me as having happened to a member of an English department. Someone gave him a drink or two the night before, and coming from that impecunious sort of profession, he wasn't used to it and I guess it was hanging with him even the next morning. He went into class and he knew he wasn't up to lecturing. This is not a personal anecdote, I'll have you know. (Laughter) So he decided to give them an essay to get the 50 minutes down and he decided to make it pretty difficult so that he'd have the 50 minutes to recuperate, if possible.

So after they sat down he said: "Gentlemen, you will write me an essay that will interrelate elements of divinity, aristocracy, nature and mystery. You may turn in your papers as you leave." And he sat down and he relaxed; he put his head on his hand, and after about a minute and a half he heard someone at his desk side and he opened his eyes somewhat laboriously and saw an eager beaver there and he said, "What's the matter, boy?"

He said, "Nothing, sir."

He said, "Didn't you get the assignment? Go write an essay that will interrelate and deal with elements of divinity, aristocracy, nature and mystery."

He said, "I've got it, sir."

He said, "What do you want me to do for you?"

He said, "I'm finished."

He said, "What did you write?"

The boy read: "'My God,' said the princess, 'I'm pregnant. Who done it?'" (Laughter) (Applause)

Well, I couldn't quite tie that up with Jesse. He is a remarkable fellow, but he has some limitations. (Laughter) But I did cast back my mind, and I think that I must warn Mrs. Mackersie that we seem to have been thinking back along equal distances because I came up with a quotation from Chaucer. She quoted Chaucer in the House today. It's his introduction to the knight. I am modernizing it so it wouldn't sound so stuck in my throat.

> "A knight there was,
> And that a worthy man,
> That from the time he first began
> To venture forth
> He loved chivalry, truth and
> Honor, freedom and courtesy.
> Full brilliant was he
> In his waging war,
> And widely had he traveled, near and far,
> He never yet no villainy nay said
> In all his life unto no man come what might:
> He was a verray parfit gentil knight."

And across the centuries the definition, the earmarks, the characteristics of a great and good man have always been the same. I've always seen Jesse as a knight, poetically sensitive, stalwart, dedicated, noble and ennobling. He moves for me in spectral shining armor, to the muted sounds of silver. He has proved himself for all of us in the lists. He has given triumphant battle. He has held our standards high and kept our honor bright. He deserves every acclamation and of love, and tonight we have our chance to acclaim him.

Ladies and Gentlemen, I give you a man whom I have grown to love because of his profound worth of soul and refined kindness of heart, the 168th President of The Medical Society of New Jersey—Jesse McCall.

(Standing ovation)

Dr. McCall: Would it surprise and probably please you that I have absolutely no prepared formal or informal text? I come to this microphone right now with two or three feelings, acute ones developed during the time we have been at dinner—one of increasing respect for the guy who has been beating the drum here so furiously for him and The Medical Society of New Jersey all during the year.

I asked Dick to take this particular job of toastmasting this ceremony several months ago, I suppose, with respect for his ability to handle the situation, not with any thought that he would develop in your minds any false ideas or ideals about the guy that is here talking to you now. However, knowing the fallibility of his tongue and sometimes his mind, the tremendous dictionary that he relies on, some of it acquired, most native, so that he can expand his ideas in glorious ways; they sound like music to your ears when he is talking about you, me, you know. I didn't intend that that would be the medium that we would use here tonight. I merely felt that he was the most competent guy that I could think of to handle the presentation of this dinner for the Auxiliary and, we'll say, honoring Louise and myself.

I have had a year of tremendous experience, valuable in so many ways, but most valuable in that it has offered an opportunity for the doctors of New Jersey. Now, that sounds like a self-sacrificing soul who has laid awake nights wondering about your problems. Not at all. Merely an opportunity to work in a definite way and in a field that's been needed and is needed still.

We have only a limited few who know much about what we are trying to do, what we should do in the future. It has been a thought of mine, right or wrong, that possibly setting some sort of example of devotion and work and dedication to a principle that it possibly may inspire someone else to work along. The only difficulty has been during the year I have been like the minister talking to his congregation. The ones who needed my words of wisdom heard them, yes. They only heard them by reference. The ones who heard them directly were right in front of me; the ones who heard them by reference were on the golf course on Sunday morning. We do not have a way, and we are still striving to get to one, to reach those that are on the golf course in medicine.

The key I have received tonight I am going to treasure greatly. There have been so many kind words, beautiful words expressed today about the success of our closing convention. They will last me for a long time. The words will lose some of their flavor; the key will be a constant reminder of all the glory of this convention.

I hope that you have gotten something from it. I hope that my contribution has been something worthwhile.

I want to thank you for Louise and myself.

Can I use a bad word? No, I won't. We have a county society, of course, that has not participated in the State Auxiliary program. You can imagine what the bad word would be for the Society. In spite of that, Mrs. Bush and the Auxiliary have done their level best to provide a wonderful entertainment in honor of your retiring president and his wife. We thank you one and all, and I particularly thank Dick for this very kind, very wonderful presentation to us.

Thank you, Dick. (Applause)

The Toastmaster: That, Ladies and Gentlemen, does it. From here on in the night shall be filled with music and the cares that infest the day shall fold their tents like the arabs and as silently steal away. From one and all of us here, the lights are dimming, happy dancing to you. There will be a floor show first, but happy dancing to you and to all a goodnight. (Applause)

(Concluded at 9:40 p.m.)

Obituaries • • •

DR. RUSH C. BAUMAN

Nutley lost one of its first citizens on November 3, 1961, with the death that day of Dr. Rush C. Bauman. Born in Philadelphia in 1885, he received his M.D. from the University of Pennsylvania in 1908 and soon thereafter established his home and office in the then pastoral surroundings of Nutley. Dr. Bauman filled the prescription for the good physician. He was a family doctor, with a special interest and skill in dermatology, and was a senior dermatologist at St. Mary's Hospital in Passaic, with affiliations at several other hospitals in that corner of the state.

Dr. Bauman, in line with the old tradition of the physician as an active citizen, took vigorous part in the civic affairs of his community. He was president of his town's Park Board, chairman of the Nutley Housing Association, and an active member of the Planning Commission. A talented landscape artist, he was widely known in horticultural circles for his original work in developing hybrid azaleas. He had had long service as Town Physician and School Physician for Nutley and was a member of the Essex County Medical Society.

DR. NORMAN M. DINGMAN

On October 18, 1961, a heart attack took the life of Dr. Norman M. Dingman, former chief of staff at St. Joseph Hospital in Paterson. Born in Rockland County, New York in 1890, he was graduated in 1915 from the College of Physicians and Surgeons of Columbia University. He then was commissioned in the medical corps of the U.S. Army and served in France in 1917 and 1918. On return from service, he opened an office in Paterson for general practice. He became increasingly interested in surgery, was made an F.A.C.S. and attending surgeon at several hospitals in Passaic County. Dr. Dingman also had a tour of duty as president of the Passaic County Medical Society.

DR. WILLIAM A. DWYER

Long a civic leader in the Passaic County area, Dr. William A. Dwyer died on November 18, 1961 at the age of 75. Dr. Dwyer received his M.D. at New York University in 1911. Five years later he joined the medical corps of the U. S. Army and served in France during World War I. He then returned to New Jersey and set up practice in Paterson. At one time he was that city's Commissioner of Revenue and Finance. Dr. Dwyer also had a tour of duty as Paterson's Police Commissioner. In 1914 he was a member of the country's electoral college and in 1947 he was one of Passaic County's delegates to the Constitutional Convention which adopted our State's present charter. He was one of the Board of Governors of St. Joseph Hospital. Dr. Dwyer was a gynecologist and obstetrician, a Board diplomate in both specialties, and a Knight of St. Gregory.

DR. CHARLES FADEM

At the untimely age of 33, a heart attack cut short the promising career of Dr. Charles Fadem. A native of Brooklyn, he was graduated from the University of Chicago in 1951 with an M.D. degree. After completing a residency in internal medicine, he successfully passed the examinations of the American Board of Internal Medicine and became a diplomate in that specialty. He opened an office in Lakewood, and became an attending internist at the Kimball Hospital there. A Fellow of the American College of Chest Physicians, he was active in the affairs of the Ocean County Medical Society. As a tragic counterpart to this death, Dr. Fadem's father, at the age of 60, died four hours later, also of a heart attack. Both deaths occurred on November 5, 1961.

DR. C. FRAZER HADLEY

Death came on November 11, 1961 to Dr. C. Frazer Hadley, past-president of the Camden County Medical Society. Dr. Hadley was 83 years old at the time of his death. An 1899 graduate of the Hahnemann Medical College, he devoted sixty years to rendering medical service to the people of Southern New Jersey. For some years he was president of the medical board of the West Jersey Hospital in Camden. Dr. Hadley was a Fellow of the American College of Surgeons.

Letters to The Journal • • •

Hierarchy - Quo Vadis?

The word "hierarchy," refers to a body of early ecclesiastical rulers or, in a biologic sense, to a series of systematic groups as kingdoms, classes, orders, families, genera and species. There have developed within the medical profession over the past twenty years, hierarchies of medical practice. Hospitals may be approved after examination of their activities by inspecting officers. Physicians in the specialties may submit themselves for examination and accreditation by inspecting boards. Schools and residency training programs (especially those of medical technology) come under the official approval of inspecting agents of the American Society of Clinical Pathologists and, finally, for completeness, blood banking facilities may be approved by inspectors of the National Institute of Health or by the American Association of Blood Banks.

The attainment of excellence is a commendable endeavor. This is especially so if the stimulus for high qualifications can be engendered at the grass roots level. It is most unfortunate, however, when excellence is viewed as a commodity which can be attained through a decree issued by someone geographically isolated, intellectually unfamiliar with and totally lacking in experience concerning the local situation in which hospital, physicians, specialists, teachers and other academically-minded personnel must, of necessity, function.

We regard change as inevitable, for life can never be a static experience. Deference to our superiors is a fundamental in any society from which chaos is to be excluded despite the intellectual diatribe of those who would have us consider that all human beings are alike. Nevertheless, the acceptance of the dictum of the medical hierarchy as absolute, without appeal and irrevocable is contrary to fundamental tenets of medical practice.

The profession has attained its present position of prestige because the individual doctor has maintained a fair-minded but receptive attitude toward all therapeutic innovations. Is it now desirable that rugged individualism become *verboten*? Is discretionary judgment of the physician, administrator, technician and teacher no longer of value to the practice of medicine and its specialties? Are hierarchial dictates going to replace good patient care at the grass roots level? Is regimentation to become the standard of professional excellence?

"Any questions, suh?"

THOMAS K. RATHMELL, M.D.

Gastroenterologists Elect New Jersey Doctors

Three New Jersey physicians were elected to office in the American College of Gastroenterology at their fall meeting in Chicago. Dr. Theodore S. Heineken of Glen Ridge became vice-president; Dr. S. Bernard Kaplan of Newark was elected a Trustee; and Dr. Louis L. Perkel of Jersey City was named as Secretary of the College. The president-elect, Dr. Edward J. Krol is from Chicago, and the treasurer is Dr. W. C. Jacobson of New York City.

Announcements • • •

Electronic Brains and Cardiovascular Disease

February 27 and 28 have been set aside for a unique symposium on the possibilities of using computers in research and diagnosis in cardiovascular disease. The meetings will be at the Sheraton in Philadelphia, sponsored by the Heart Association of Southeastern Pennsylvania. A blue-ribbon faculty, representing both clinical medicine and computer engineering has been recruited. For detailed program write to Dr. H. Donald Burr at Heart Association, 318 South 19 Street, Philadelphia 3, Penna.

Pharmacology and Therapy Award Offered

To the author of an original paper on any aspect of pharmacology or therapeutics, the American Therapeutic Society is offering a $500 cash award plus travelling expenses to the June 1962 convention of that Association. For young physicians only, this is limited to interns, residents, Fellows or to doctors whose residency or fellowship terminated in or subsequent to 1958. For details write to Dr. Oscar Hunter, 915 Northwest 19 Street, Washington 9, D. C. Deadline for this competition is March 1, 1962.

Eye and Ear Alumni

A meeting of the Alumni Association of the New York Eye and Ear Infirmary will be held April 9 to 12, 1962. One session will be oriented towards cataracts. There will also be courses and a closed circuit television demonstration of surgical procedures.

Another meeting will be on complications of stapes surgery, and on the significance of a mass in the neck as well as lectures and television demonstration of surgical procedures. For details, write to Alumni Association, 218 Second Avenue, New York 3, N. Y.

Pediatric Oncology Course

The Memorial Sloan-Kettering Cancer Center announces that the annual comprehensive three-day course in pediatric oncology for pediatricians and general practitioners will be held in New York on April 25, 26, and 27, 1962.

Current developments and methods in diagnosis, differential diagnosis and management of benign and malignant tumors, Hodgkin's disease, leukemia and reticulo-endothelioses in childhood, are included. The course includes ward rounds, seminars, demonstrations, examinations of children in pediatric, surgical, chemotherapy and radiotherapy clinics.

The class is limited to 15 physicians. The fee is $40.

For more information, write to Department of Pediatrics at Memorial Sloan-Kettering Cancer Center, 444 East 68th Street, New York 21, New York.

Want to Read a Paper in Miami?

The Section on Ophthalmology and Otolaryngology of the Southern Medical Association will now accept papers for presentation at Miami Beach, November 12 to 15, 1962. Deadline for submitting your manuscript is May 15, 1962. For details, write to Dr. Albert C. Esposito, First National Bank Building, Huntington 1, West Virginia.

Ophthalmology Fellowships Available

A number of $1800 a year, three-year fellowships are being sponsored by the Guild of Prescription Opticians. These are being distributed geographically throughout the country, one in each area. For details, write to Guild of Prescription Opticians, 110 East 23 Street, New York 10, N. Y. Deadline for applications is May 15, 1962.

County Society Reports • • •

Atlantic

A regular meeting of the *Medical Society of Atlantic County* was held in the Children's Seashore House on Friday, November 11, 1961. Dr. Josiah McCracken presided. The speaker of the evening, introduced by Dr. Frederick Panico, was Dr. Robert G. Bloch, chief of Pulmonary Diseases in the Montefiore Hospital in New York City. Dr. Bloch gave a very interesting discussion of experimental work which he has been conducting on tuberculous calcification. His talk led to a lively discussion by Drs. Ellenbogen, Catanzaro, Konzelman, Gross, and Southard.

Diabetes Detection Week will be observed November 12 to 19 and packs are available for distribution to the public; posters are available for doctors' offices; and Dr. Carol Kramer will discuss diabetes on our weekly radio program under the direction of Dr. Victor Ruby—"Your Doctor Speaks."

The Censorship Committee has approved for Associate membership in our society the name of Dr. George Keates. This was approved.

Dr. Southard discussed the problem of teenagers who have been inhaling the fumes of cement or glue. Dr. Grier, the health officer in Pleasantville and the police there have been handling the problem.

The meeting ended with usual collation.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society*, held at Kohler's Swiss Chalet at Rochelle Park on November 14, 1961, was a joint dinner meeting with the Bergen County Bar Association. Dr. Wahrenberger, president, called the meeting to order after announcing that the business meeting would be confined to approval of previous minutes and election of new members.

The following applicants were elected to membership: *To Active by transfer*—Harold Goldberg (from County of Kings, New York); George Himadi (from Union County); John S. Winston (from Passaic County); To *Active from Courtesy*—Arthur A. Goldfarb (from Bronx County, New York); *To Active from Associate*—Samuel Clark, Jr., Robert G. Kerdasha; *To Associate*—Stanley Karp, Thomas Sofianides.

Prior to the business meeting, Mr. William R. Morrison, president of the Bergen County Bar Association, greeted the approximately 225 attorneys and physicians (113 of whom were Bergen County Medical Society members) in the name of his association and introduced John R. Kelly, Esquire, past-president of the New Jersey State Bar Association. Mr. Kelly expressed his pleasure at the invitation to attend this first joint interprofessional meeting and expressed the hope that the purpose of the meeting would be successfully accomplished.

After completing the business meeting, Dr. Wahrenberger presented Dr. Jesse McCall, Past-President of The Medical Society of New Jersey. Dr. McCall thanked the Bar Association and the Medical Society for giving him the opportunity of attending. He spoke briefly about the pilot program of the State Society now in the process of establishment, to provide a panel of impartial medical witnesses for the assistance of the court in making available medical testimony in public liability and personal injury suits.

Mr. Morrison presented Mr. Donald G. Borg, editor of "The Record," as moderator of a panel of two physicians and two attorneys, who spoke on the following subjects: "The Production of Medical Testimony"—Spencer T. Snedecor, M.D. and Roger W. Breslin, Esq.: "The Implementation of the Interprofessional Code"—Herbert E. Reinhold, M.D. and Charles C. Shenier, Esq. A question and answer period followed.

This combined meeting was lively and of exceptional interest to both lawyers and doctors and will probably become a yearly event.

CHARLES P. CAMPBELL, M.D.

Reporter

Burlington

The *Burlington County Medical Society* opened its new Society year on September 14, 1961 with Dr. Ralph Van Meter, its president in the chair. Forty-five regular members, six associate members, and six guests were in attendance. A panel discussion on "Civilian Defense" was moderated by Dr. Winfield Betts, Medical Director of Civil Defense and Disaster Control for Burlington County. The panel consisted of Edmond Maguire, Coordinator of Civil Defense and Defense Control for Burlington County; Colonel F. Wolf, M.C., from McGuire Air Force Base; John Hatfield, Administrator of the Burlington County Hospital and Dr. Lindley Reagan, Chief, Department of Surgery, Burlington County Hospital. Discussion evolved around the physician's role in disaster, the need of organization in this respect, the problem of fall-out irradiation and active and prophylactic care for this.

The President announced the resignation of Dr. Robert Heal as secretary. Dr. Amy Barton will be his replacement. Dr. Roland Stratton was appointed to the executive committee.

The proposed revision of the constitution was presented and after several suggestions was accepted. Elected to full membership were Doctors Abrams, Flinker and Greenfield.

The death of Dr. Jacob Davis on August 2, 1961 was announced.

The *Burlington County Medical Society* convened in regular session at the Millside Farms Dairy Bar, Riverside, on November 9, 1961 with Dr. Lindley Reagan presiding. There were 31 regular members present plus six associate members, and a guest. The program opened with a panel discussion on "Rehabilitation of the Stroke Patient," presented by Dr. Alvin Florin, Coordinator of the Heart and Circulatory Disease Program of the Division of Chronic Illness Control, State Department of Health, Mrs. Patricia Hanna and Mrs. Cleora Brown, Special Projects Coordinator, Restorative Services Program. An informative discussion and demonstration of methods of rehabilitation used by the stroke patient at home and in the hospital were presented.

The revised constitution and bylaws were approved and promulgated.

New members elected to full membership were Drs. Brill and Saltzner.

It was agreed that Mrs. Bunning's title be changed from stenographer to Executive Secretary.

JOHN W. ARBOGAST, M.D.

Reporter

Middlesex

The regular monthly meeting of the *Middlesex County Medical Society* was called to order by the president, Dr. T. F. McLaughlin at 9:00 p.m., November 15, 1961 at Roosevelt Hospital in Metuchen.

The minutes of the October meeting were approved as read.

The following applications—as presented by Dr. B. F. Slobodien, Chairman of the Judicial Medical Ethics Committee—were approved for presentation to the Credentials Committee of The Medical Society of New Jersey for membership election: To Regular membership from two years' Associate membership—Drs. Jerrold S. Finkel, Fords, Max Novich, Perth Amboy by transfer from Essex County Medical Society and N. B. Cole, Perth Amboy by transfer from Monmouth County Medical Society. To two years' Associate membership—Drs. W. Donald Horrigan, Nicholas M. Nelson, Michael Sokol and Paul Treitman, all of New Brunswick.

The guest speaker, Dr. Felix J. Wrobelewski, Director of Enzymology, Memorial Hospital, New York City, was introduced by Dr. Robert J. Zullo. His lecture on medical enzymology was well received. He stressed the limitations of the enzyme tests such as serum transaminase, serum amylose and acid phosphatase.

In keeping with the plan of having a variety of informative meetings, Dr. Rudolph Matflerd stated that our next speaker would be a lawyer, Mr. Joseph Brophy, Counsel to the American Medical Association, who will discuss malpractice.

Dr. Akey, Chairman of the Public Relations Committee, presented the plan to accept half of the cost of advertising for tetanus immunization inoculations for Middlesex County. The plan was accepted.

It was agreed that Dr. Matflerd's program committee be empowered to arrange with the pharmacists for entertainment at our meeting with them at Oak Hills Manor.

The meeting was then adjourned and collation served.

EUGENE L. CHILDERS, M.D.

Reporter

Passaic

The annual installation dinner meeting of the *Passaic County Medical Society* was held on October 11, 1961 to introduce Dr. David B. Levine as president, and the other officers of the Society.

Rabbi Harry A. Bornstein gave the invocation. Then Dr. Sandor A. Levinsohn served as Master of Ceremonies.

The retiring president, Dr. F. Albert Graeter, was presented with a plaque in appreciation of his services during the past year.

Dr. David B. Levine, the newly installed president, called upon the members to adapt to changing times by shaping the society "into a dynamic, community-oriented organization which can change the image of the physician in the public mind." This will require, he said, attendance at meetings, active participation in committee work, continued graduate education, advancement of standards of practice and maintenance of the esteem of the public. Dr. Levine stated that there are two contradictory facts with which physicians must contend: American medicine, in the mind of the American public, is the best in the world, but millions of people are bitterly dissatisfied with the medical care they are getting. It is up to physicians to change this by objective analysis and effective action.

The other officers installed were: Dr. Francis R. Meyers, *First Vice-President;* Dr. Marion F. Kaletkowski, *Second Vice-President;* Dr. Irving Chrisman, *Secretary;* Dr. Frank B. Vanderbeek, *Treasurer;* Dr. James A. Rogers, *Assistant Treasurer;* Dr. Alex E. Schefrin, *Reporter* and Dr. John A. Ianacone, *Editor.*

Invited guests of the Society were: Dr. Ralph M. L. Buchanan, President, and Mr. Richard I. Nevin, Executive Officer, of The Medical Society of New Jersey, both of whom addressed the group briefly; also Dr. Walter Wahrenberger, president and Charles P. Campbell, secretary, of the Bergen County Medical Society. Other guests included Frank X. Graves, Mayor of Paterson, Stanley

Zwier, Mayor of Clifton and Paul G. De Muro, Mayor of Passaic; Mr. Harvey Schoenfeld, Director of the Barnert Memorial Hospital; Mr. John De Ritter, Assistant Director of the Paterson General Hospital; Mr. L. R. Pesa, Assistant Administrator of St. Mary's Hospital; Mr. David Wachs, Superintendent of the Beth Israel Hospital; Mr. Gerald M. Krantz, Assistant Administrator of Chilton Memorial Hospital; Mr. Richard Drukker, president of *The Herald News;* Mr. Henry A. Williams, publisher of The *Morning Call;* Mr. Charles Van Wagner of the *Paterson Evening News;* Mr. Donald E. Asbel, president of the Passaic County Pharmaceutical Association; Irving A. Rubin, president of the Passaic County Bar Association; H. C. Rivetti, D.D.S., president of the Passaic County Dental Society and Martin Klughaupt, Counsel to the Passaic County Medical Society. It was a pleasure to have as guests many emeritus members including Drs. Andrew B. Vanderbeek, Louis Lipton, Sante Giambra and Ralph J. Vreeland.

Dr. Levinsohn then introduced the guest speaker, Dr. Mason W. Gross, president of Rutgers, who spoke on the proposed new medical college for Rutgers. The talk was exceptionally interesting and was enthusiastically received by the 200 members and guests attending the dinner.

ALEX E. SCHEFRIN, M.D.

Reporter

Salem

At its regular monthly meeting on November 17, 1961, at Richman's Ice Cream Company in Sharptown, the *Salem County Medical Society* voted to establish a permanent committee on radiation problems. The president of the society, Dr. William Sprout, appointed Dr. Eugene Pashuck of Woodstown as chairman of this committee, to be assisted by Drs. Joseph Stasney, Loring Sylvester, and Captain Edwin Kellerman, medical officer at the Nike missle base at Pedricktown. Dr. Pashuck was also designated as the Society's official spokesman on radiation safety, to facilitate clarification of questions from Civil Defense authorities or from the general public.

The Woman's Auxiliary were authorized to cooperate with the Civil Defense program, under the direction of their appointed advisor, Dr. C. Spencer Davison. Dr. John Madara introduced the motion calling for the formation of the Radiation Problems Committee by citing summaries of current opinion in the treatment of radiation injuries.

Dr. John Howard, Professor of Surgery at Hahnemann, discussed recent advances in the surgical and chemical methods in the therapy of cancer.

Dr. Sprout read a letter written to the Society this week by Dr. Sanford G. Rogg, clinical director of the Salem County Guidance Center. Dr. Rogg had addressed the group at its previous monthly meeting and had been asked at that time if figures were available to show whether the Guidance Center operations represented a gain or a loss to the county treasury. He was able to state that Salem County had one of the highest ratios in the state of its residents in the Ancora State Hospital at Hammonton, resulting in an annual expense to the county of about $400,000. Dr. Rogg's letter adds that "In the past ten months there has been a 17 per cent decrease in the number of Salem County patients admitted to our State hospitals. This represents a savings of approximately $65,000 to Salem County. Since the only new element introduced has been the Guidance Center, I feel that it should be credited for a major part of this saving."

JOHN T. DOOLEY, M.D.

Reporter

No Headlines for Quacks

"Early in the Kefauver hearings, the subcommittee invited testimony from the Arthritis and Rheumatism Foundation. There followed appalling disclosures that $250 million are spent each year by arthritics on quack cures. Considering the close attention of the press and public to these proceedings, never had a Congressional inquiry been handed a finer opportunity to launch a public crusade and mobilize national resources to stamp out criminal operations in the health field. And what happened? Nothing. The investigators were more interested in the assault on manufacturers of corti one and its derivatives which have actually restored millions of cripples and potential cripples to useful, productive life." —*Report to the Nation*: Austin Smith, M.D., President, Pharmaceutical Manufacturers Association.

Book Reviews • • •

A Synopsis of Contemporary Psychiatry. George A. Ulett, Ph.D., M.D. and D. W. Goodrich, M.D. St. Louis, 1960. Mosby. Ed. 2. Pp. 309. ($6.50)

In a flexible-covered book, small enough to fit the side-pocket of a medical coat, Ulett and Goodrich have compressed a remarkable compendium of psychiatry. The authors cover technics of psychiatric interviewing, a formulation for a complete case study, methods of neurologic survey (including tests for aphasia) electro-encephalographic interpretation and psychologic tests. They explain the classification of emotional illness and the dynamics of personality development. And in a creditably concise way they spell out various treatment modalities including psychotherapy, shock treatment, psychosurgery, and pharmacologic therapy. There is a chapter on psychiatric aspects of disaster relief and another on management of the suicide-prone patient.

Apparently this handbook is intended as a *vade mecum* for beginning psychiatric residents and for general practitioners. It is an excellent refresher for any doctor. Somehow the authors have achieved compactness without being misleadingly superficial.

HERBERT BOEHM, M.D.

A Manual of Cutaneous Medicine. By Donald M. Pillsbury, M.D., Walter B. Shelley, M.D., and Albert M. Kligman, M.D. Philadelphia, 1961. W. B. Saunders Co. Pp. 430, illus. ($9.50)

The preface outlines the goals of its authors: "To summarize the physiology, chemistry and anatomy . . . most useful in promoting an understanding of the genesis of dermatologic disease; to emphasize those changes in the skin which may be representative of systemic disease; to hew the line of forthright and simple terminology; to assess the usefulness and hazards of methods of treatment; to indicate diseases which may ordinarily be managed effectively in general practice and those in which more specialized methods and experience may be essential and to substitute pictorial materials and diagrams for text wherever clarity and brevity will be increased thereby."

The authors have achieved these aims. They have swept away many of the hypotheses, suppositions and plain errors which have been re-appearing for so many years in dermatologic texts. The succinctness enhances the value of this book to the medical student, the general practitioner and even to the busy dermatologist who has been getting a bit rusty. The writing is in crisp prose rather than "technicalese." The formulary at the end of the book contains an excellent resumé of the uses and limitations of glucosteroids in dermatologic therapy.

Most refreshing is the pictorial material. For example, a sketch of "the only truly specific treatment of miliaria" depicts a youth wearing a pair of trunks only, completely relaxed in a hammock, in the breeze of an electric fan. The section on atopic dermatitis illustrates all that is good in this book. It stresses the family psychiatric factors, the abuse of "skin tests" and the importance of treating a patient rather than a disease. The picture of the atopic infant on page 92 captioned "Atopic Dermatitis and Unhappiness" should win first prize in any photography contest.

This is the best brief dermatologic textbook I have read.

JACOB BLEIBERG, M.D.

The Cardiac Arrhythmias: A Guide for the General Practitioner. Brendan Phibbs, M.D. St. Louis, 1961. Mosby. Pp. 125, with 154 tracings. ($7.50)

In this short review of cardiac arrhythmias, Dr. Phibbs deals with the rhythm abnormalities, discusses their pathogenesis, clinical and electrocardiographic appearance and summarizes specific therapy. It is kept clear and simple, although some basic knowledge of electrocardiography is necessary for its full appreciation. Emphasis is on the need for cardiographic confirmation of the type of arrhythmia, a point which cannot be overstated. No cardiac arrhythmia should ever be treated without this, as clinical differentiation is frequently next to impossible and treatment varies according to the diagnosis. The classical example of atrial tachycardia with block is cited: this will mimic auricular fibrillation and other abnormalities clinically, but the treatment for these is quite different, and proper recognition may make the difference between a fatal and a successful outcome.

A chapter is devoted to the problem of cardiac arrest both in and out of the operating room, with the proper emphasis on quick and well-planned action. The author relies heavily on the direct approach with immediate thoracotomy, and mentions the recently developed closed chest cardiac massage only in passing. This technic will probably turn out to be the most useful and least harmful tool in this area.

This excellent book should be in the hands, not only of general practitioners for whom it is intended, but also of all who are interested in and deal with these aberrations of cardiac mechanism.

GERALD MUEHSAM, M.D.

Neurology Simplified. David Joseph LaFia, M.D. Springfield, Illinois 1960. C. C. Thomas. Pp. 175. ($6.75)

The general practitioner's unfamiliarity with neurology is unfortunate. It means that many neurologic disorders are dismissed as "neurotic" until irreversible changes set in. To meet the need of the general practitioner, LaFia has written this remarkably compact handbook. The illustrations are clean and comprehensible. The language is friendly and familiar—as when LaFia tells us, in examining the scalp, "to look for lumps and bumps," when he warns against giving the patient a "brush-off," or mentions diagnostic "gadgets." The author speaks to "you"—thus identifying the reader. Using this book is almost like having a mellow neurologist right at your side, giving tips on examination and treatment.

The only objectionable feature of the text is the author's enchantment with trade names—Trilene, Bonamine, Cafergot—and the like. This is too bad, since generic names would get away from recommending specific proprietary brands.

LaFia also tells you what *not* to do. The chapter on headache is a handy monograph in its own right. It is astonishing how much meat the author has packed into this small container.

HENRY A. DAVIDSON, M.D.

Heredity in Ophthalmology. Jules Francois, M.D. St. Louis, 1961. Mosby. Pp. 731 with 629 figures. ($23.00)

This book, by the professor of ophthalmology at the University of Ghent, Belgium, represents the result of exhaustive study, research and preparation. The writing is concise and clear. The facts are logically arranged and buttressed by tables, charts and diagrams.

A careful reading of the first two sections on "general genetics" and "genetics in ophthalmology" is essential to proper understanding and appreciation of the subsequent parts of the hereditary diseases of the eye as well as the more generalized diseases with some ocular signs and symptoms. The bibliography is large and carefully annotated. Many chapters which appear quite complicated are (gratefully) clarified by a closing summary of the salient points.

Of particular interest is a complete outline on the different modes of inheritance of eye diseases and defects.

This reviewer is particularly impressed by the forthrightness and directness of the author's style. There is so much "meat" in these pages that it must be slowly and carefully digested. This book is an excellent text and reference work and should give the ophthalmologist the background for intelligent advice to his patient.

S. JEROME GREENFIELD, M.D.

The Family Handbook of Home Nursing and Medical Care. I. J. Rossman, M.D. and Doris Schwartz, R.N. Garden City, 1961. Doubleday. Pp. 519. ($1.45)

Many books have been written on what to do until the doctor comes. This one tells what to do after the doctor has gone. It is filled with sensible advice to the people at home who have to take care of the sick one. It never talks down. In addition to material on first aid and household emergencies, there is a series of wise chapters on living with an ulcer, or with diabetes, and other chronic ailments. The chapter on cancer control is at once hopeful and realistic, tender and practical. There are sections on how to get help, how to prepare diets, how to set up sick-room divertisements, geriatric care, and elementary physiology. A hundred-page section is organized as an almanac of nursing procedures—alcohol sponges, care of amputation stumps, maintenance of asepsis, bathing, use of thermometers, bedpans, carrying helpless patients up and down stairs, use of crutches, foot care, elimination of lice, oral hygiene, and even how to make a bed while the patient remains in it. The writing style is vivid, clear and smoothly readable. This is a good book to give to the family of chronically sick patients; and it makes a handy springboard for the physician called on to give a talk to lay audiences.

ULYSSES M. FRANK, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JANUARY, 1962 • VOL. XXXV, NO. 1

CLASSIFICATION OF PULMONARY TUBERCULOSIS

A new edition of Diagnostic Standards and Classification of Tuberculosis—the eleventh—redefines the terms to be used in primary and reinfection disease.

No single system of classification can give information which completely describes the lesions of tuberculosis. However, certain basic categories are needed for records and for statistical purposes. There are also optional classifications which may be used for a comparison of disease characteristics and which may include general status of the patient, pathologic character of lesions, detailed location of lesions, pathogenic status, mode of dissemination, dynamic status, duration of disease, and previous treatment.

The basic classifications should include the following: extent of disease, status of clinical activity, therapeutic status, and exercise status.

Extent of Disease. The total extent and location of pulmonary lesions are decided from examination of chest roentgenograms.

Minimal lesions include those of slight to moderate density without demonstrable cavitation. They may involve a small part of one or both lungs, but the total extent should not exceed the volume of lung present above the second chondrosternal junction and the spine of the fourth or the body of the fifth thoracic vertebra on one side. The term minimal is not to be interpreted as minimizing the activity or hazards of the disease in this stage.

Moderately advanced lesions may be in one or both lungs, but the total extent should not exceed the following limits: disseminated lesions of slight to moderate density extending throughout the total volume of one lung or the equivalent in both lungs; dense and confluent lesions limited to one third the volume of one lung; if cavitation is present, its total diameter must be less than 4 cm.

Far advanced lesions are all those more extensive than moderately advanced.

Both original extent of disease and change in extent must be noted.

Status of Clinical Activity. The activity of pulmonary tuberculosis is based largely on roentgenographic and bacteriologic factors and their duration. Determination of bacteriologic status must include the use of sputum concentrates, cultures, and animal inoculations, or similar tests of gastric aspirates or lavages. A positive bacteriologic finding means the presence of tubercle bacilli by microscopy of sputum specimens, preferably confirmed by culture or guinea pig inoculation. Susceptibility studies should be made for the major antituberculosis drugs whenever possible.

Roentgenographic status should be determined by serial posteroanterior films, where feasible, by planigrams and other supplementary films.

Active pulmonary tuberculosis may be so

Diagnostic Standards and Classification of Tuberculosis, 1961 edition, published by the National Tuberculosis Association.

classified on the basis of one or more of the following criteria:

If the probability of change is obvious on a single chest roentgenogram or if change for better or worse is demonstrable on serial roentgenograms at intervals of six months or less.

If tubercle bacilli can be demonstrated in the sputum, gastric aspirates or tracheal aspirates.

If such complications as tuberculous empyema, bronchial or pleural fistula, or active endobronchial tuberculosis are present, the associated pulmonary tuberculosis must be classified as active even if other criteria are not apparent.

Duration of activity should be designated if known. The terms "improved," "unimproved," or "worse" may be added to "active" after an interval of observation.

Quiescent is a newly reinstated term to be applied to a class intermediate between active and inactive. It denotes negative bacteriologic findings (a negative bacteriologic finding means that adequate examinations have been made to exclude the presence of tubercle bacilli) on monthly examinations for at least six months and stable or slowly improving lesions visible by roentgenography, although cavitation may be present. The "open-negative" is in this category.

Inactive denotes constant and definite healing. Bacteriology must have been negative on monthly examinations for at least six months by all methods used. Serial roentgenograms must show stability and no evidence of cavitation for at least six months.

Tuberculosis may be temporarily classified as *activity undetermined* if adequate bacteriologic and roentgenographic examinations have not been completed, or if observation has been too brief.

Therapeutic Status. Chemotherapy and surgical collapse or excision, when used, should be added to the terms applied to clinical status.

Exercise Status. The amount of exercise prescribed should be designated as: I. Bed rest (varies from strict immobilization to bathroom privileges). II. Semi-ambulatory (rest and exercise combined). III. Ambulatory (a greater amount of exercise). IV. Ordinary living conditions (the amount of exercise equals full activities of home life and work).

PRIMARY TUBERCULOSIS

The basic features of primary tuberculosis should include data on tuberculin tests, bacteriologic data, roentgenographic findings, symptoms, and extrapulmonary tuberculosis.

Classification. Primary tuberculosis may be classified as to extent of lung lesions and status of activity. The extent is classified the same as for reinfection tuberculosis. Activity is classified as follows:

Active—A positive tuberculin reaction plus one or more of the following: tubercle bacilli in the bronchial secretions or gastric contents; roentgenographic evidence of activity in a parenchymal, pleural, or lymph node lesion. Tuberculin reactors less than 36 months of age or those of any age who have converted from nonreactors to reactors within the previous years are often treated as active primary tuberculosis even in the absence of other evidence of activity, but should not be reported as active primary tuberculosis.

Inactive—Absence of criteria of activity.

Undetermined—No classification with repect to activity can be made due to lack of data.

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1. Soll mann, T.: A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology, ed. 8, Philadelphia, W. B. Saunders Company, 1957, p. 206.

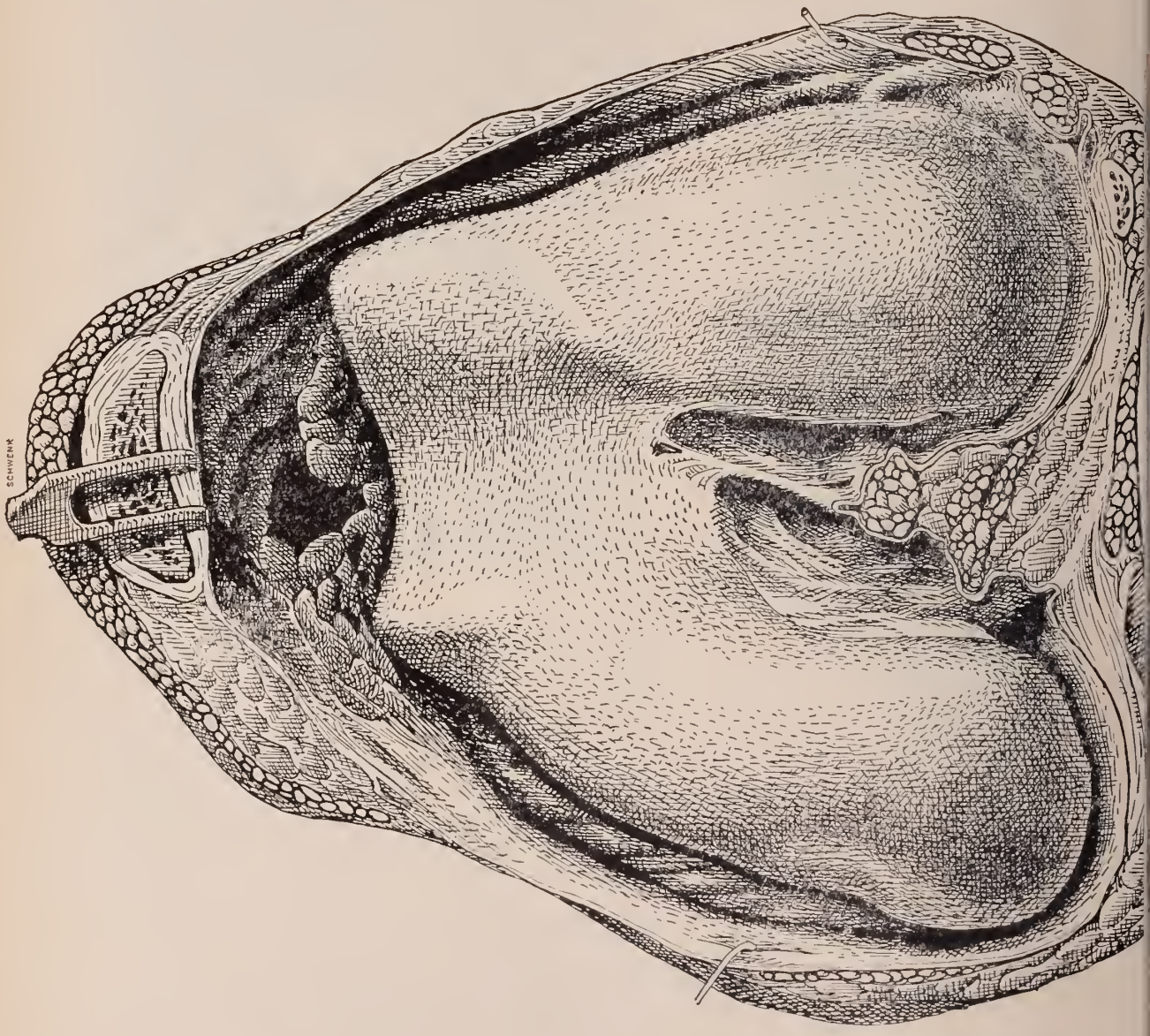
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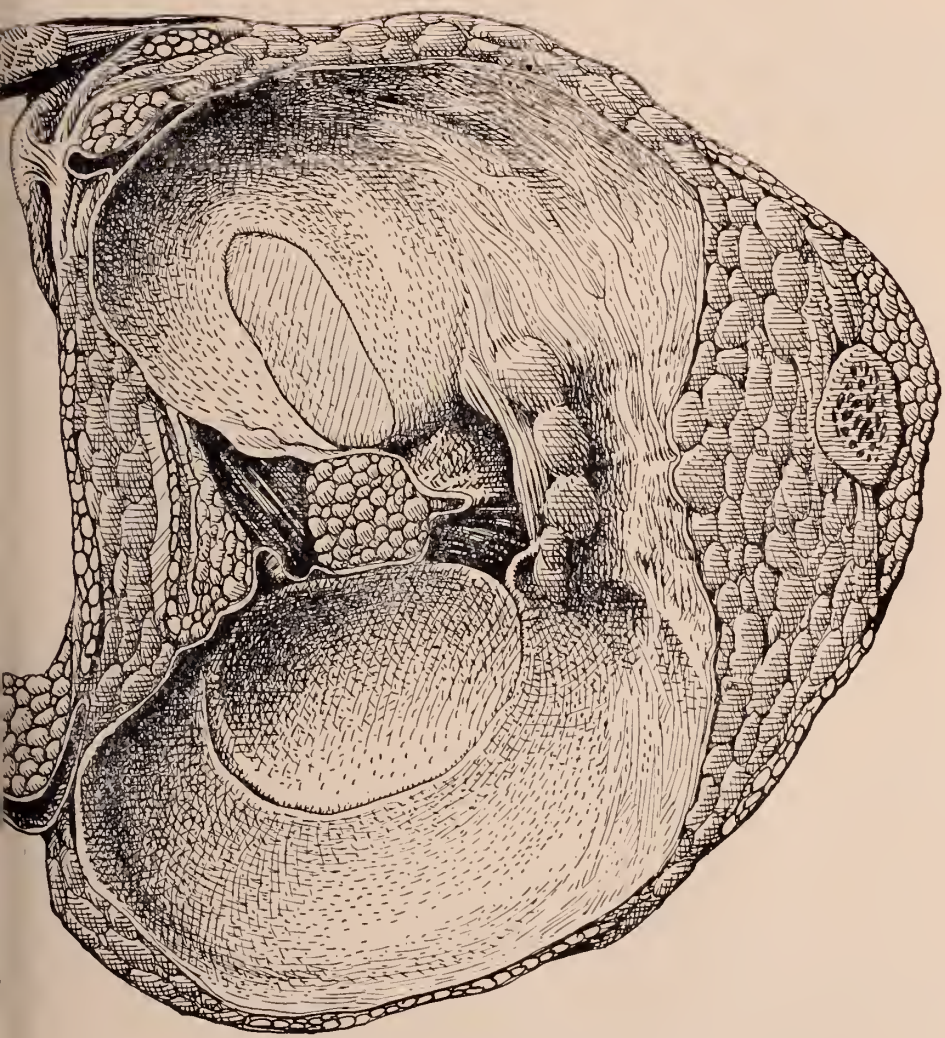
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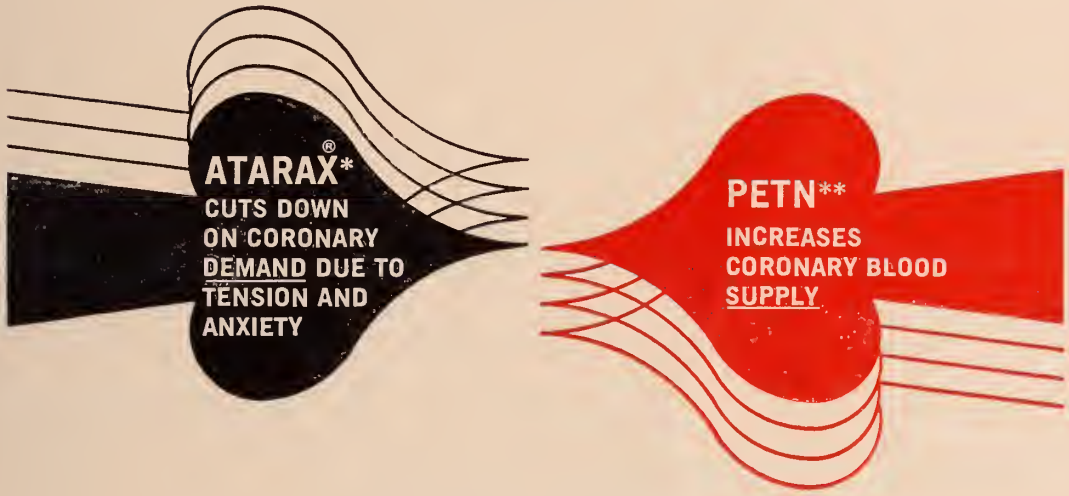
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1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L.: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sidwell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C.: in Stieglitz, E. J.: Geriatric Medicine, 3rd edition. J. B. Lippincott, Philadelphia, 1954, p. 264

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A. Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:72 (Dec.10) 1960

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan, G. G.: Diseases of Metabolism, 4th edition. W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958

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(Continued from preceding page)

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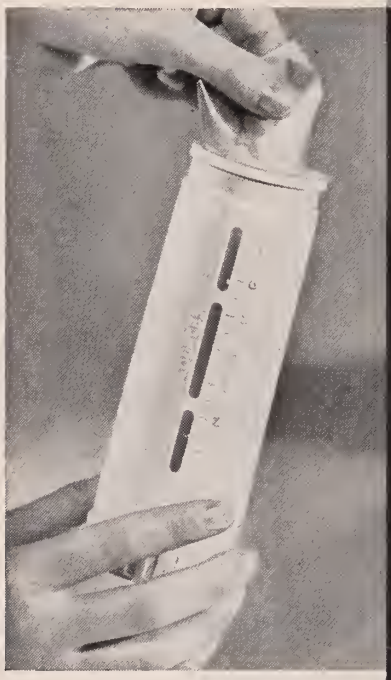
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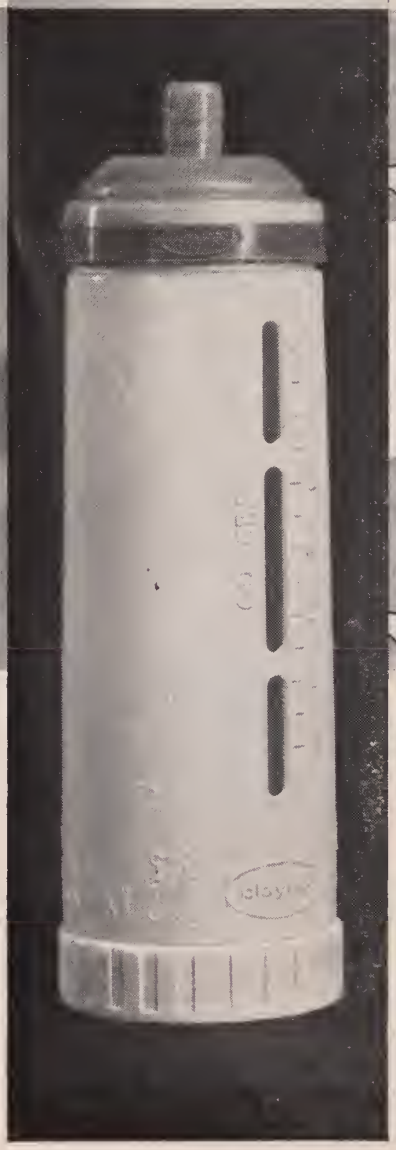
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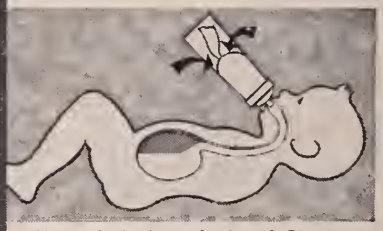


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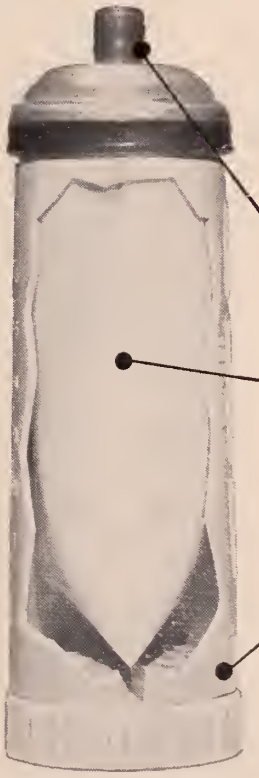
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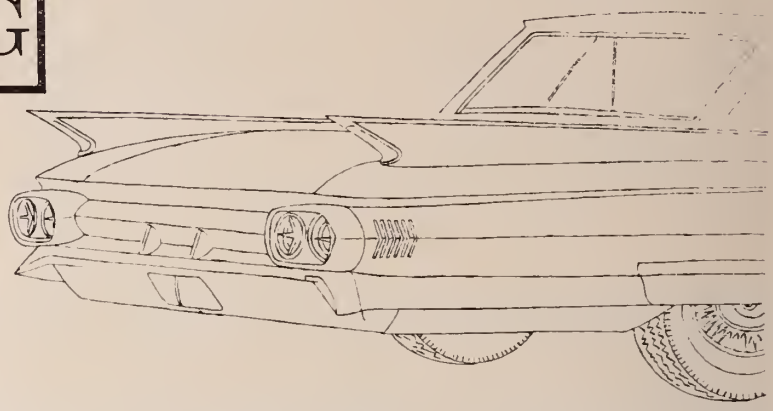
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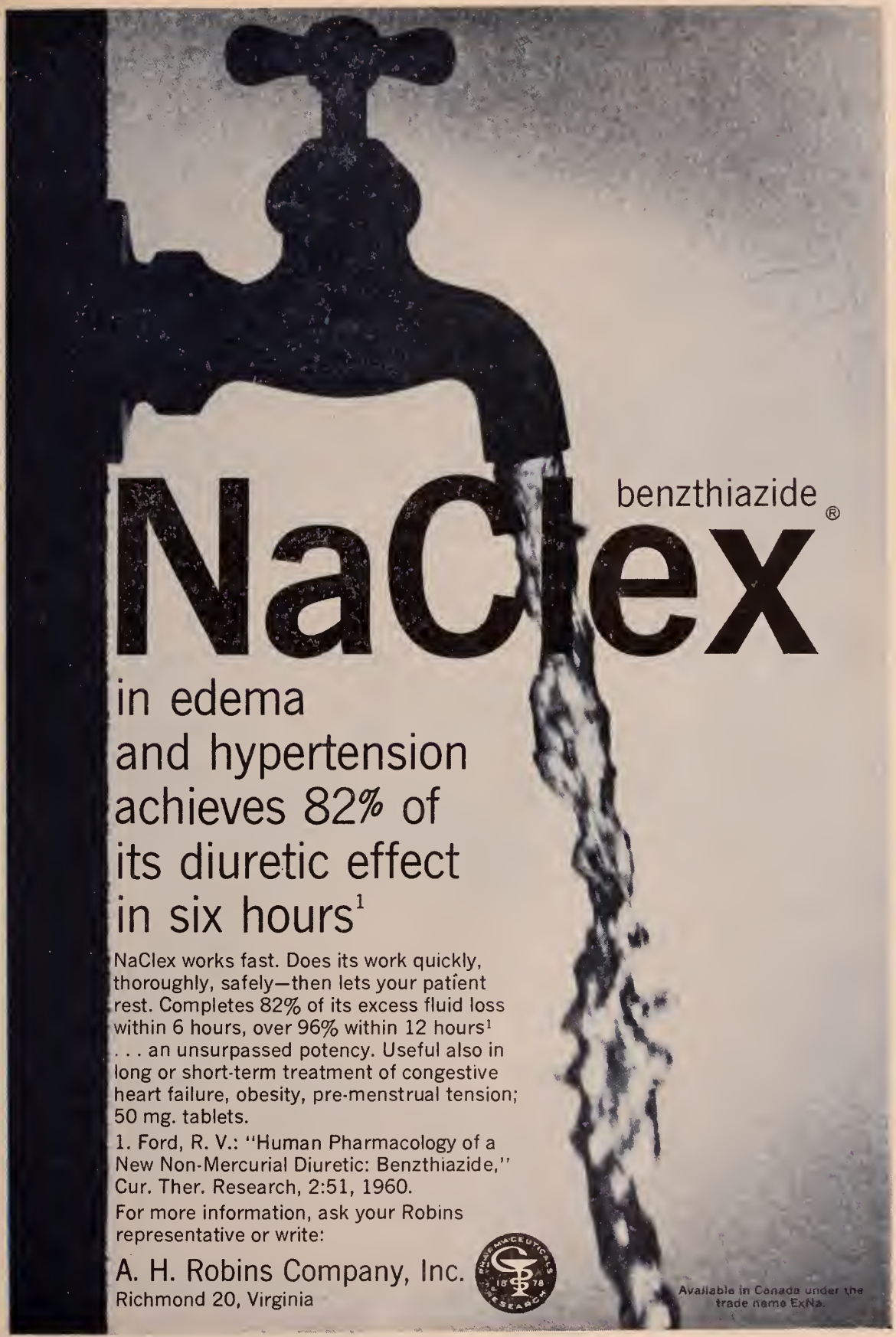
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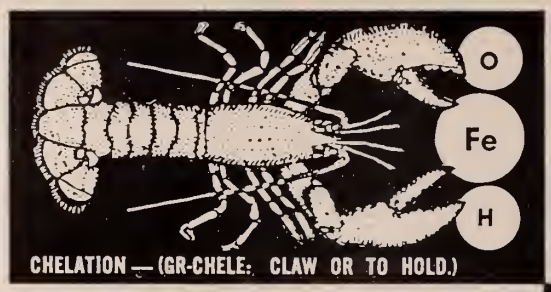
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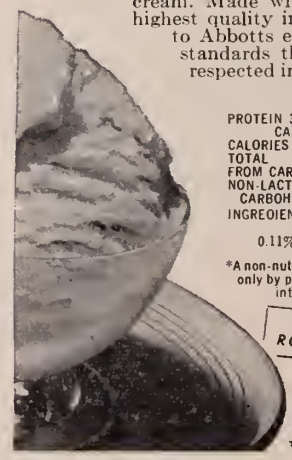
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References: (1) Malone, F. J., Jr.: *Mil. Med.* 125:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* 34:187, 1959. (3) Ullman, A.; *Delaware M. J.* 32:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* 108:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* 10: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* 11:392, 1960.

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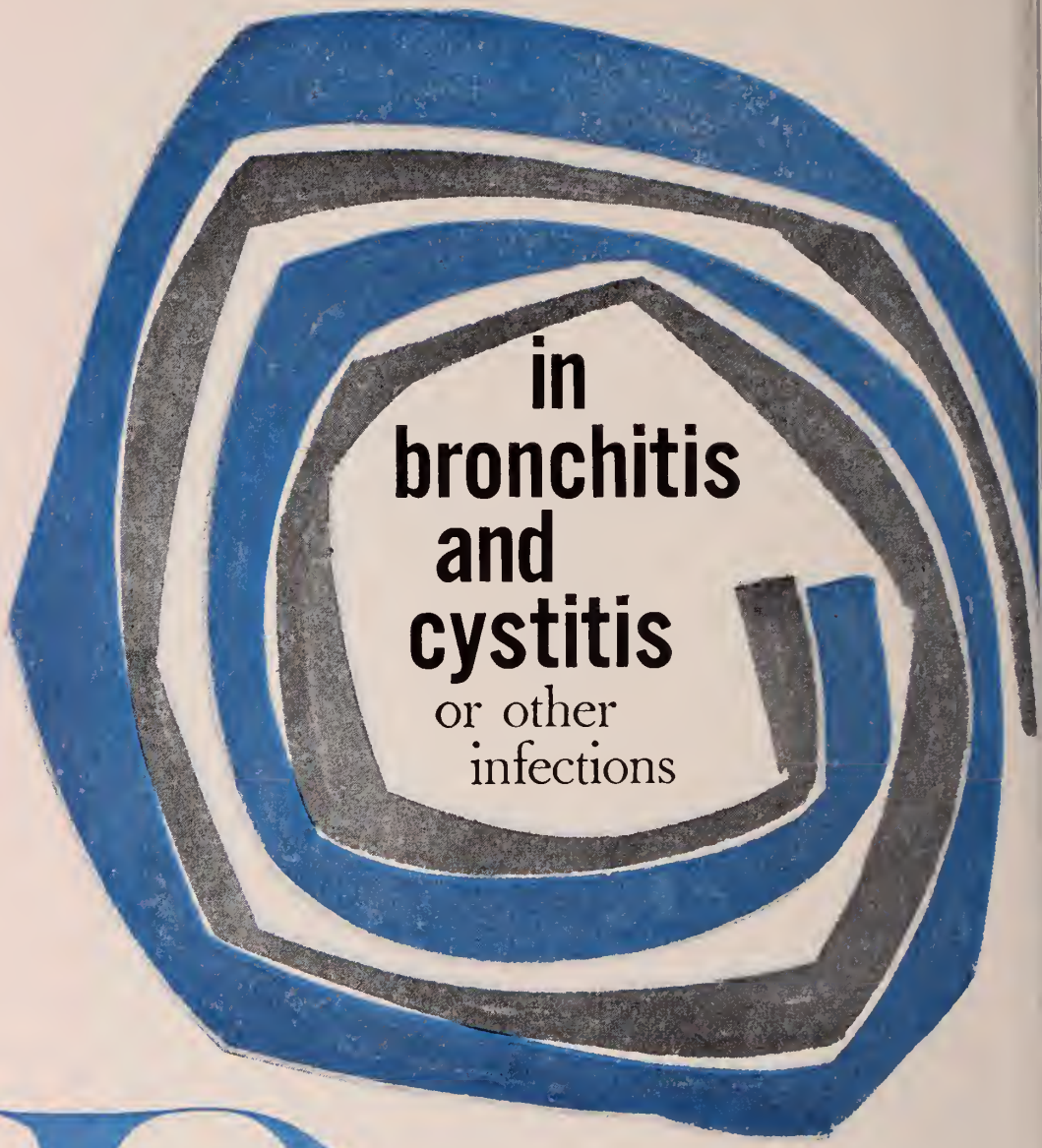
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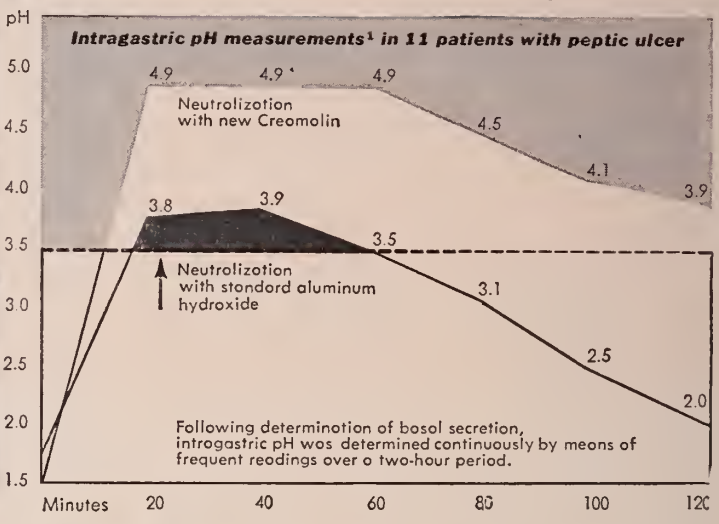
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References: 1. Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. 2. Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. 3. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. 4. Data in the files of the Department of Medical Research, Winthrop Laboratories. 5. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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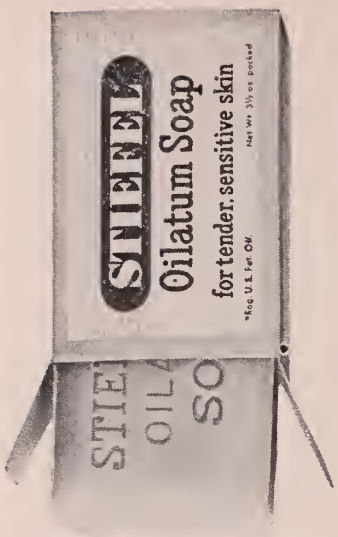
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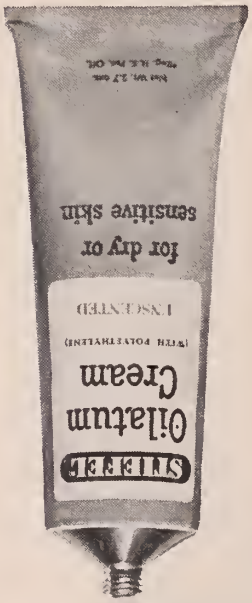
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First of all, what does "rigid-ring" mean?

Briefly, this: it describes the use of a fixed pyrrolidine pentagon, or rigid ring, which guarantees a constant 2-carbon distance between reactive parts of the molecule. In line with the "receptor site" concept of the mechanism of action of anticholinergics, this almost inflexible molecule is theoretically more likely to "fit" only certain receptor sites.

Theories are all right, but is Robanul really more selective?

Yes! Evidence of its selectivity can be seen by the surprising lack of typical secondary anticholinergic effects (dry mouth, blurred vision, etc.) that occur at the effective dosage level of 1 to 4 mg. a day. Out of 499 duodenal and gastric ulcer patients treated at this level in investigative studies, only 4.4% had complaints of moderate to severe effects.

How is it for reducing gastric acid?

One investigator[1a] found that a 2 mg. dose of Robanul lowered acid secretion 73% in one hour (compared to a basal-hour period) and 84% in two. A 4 mg. dose dropped secretion over 94% in one hour and 97% in two!

What about acidity, or concentration of acid?

In one study, glycopyrrolate produced significant suppression of pH to 4.5 or higher in 5 of 5 duodenal ulcer patients given a 4 mg. dose, 7 of 8 patients given 2 mg., and 4 of 5 patients given 1 mg.[1b]

Will Robanul depress gastric hypermotility?

In another study[2] with six subjects Robanul decreased gastric motility in every patient. Within 40 minutes after the administration of 2 mg. of Robanul, the frequency of gastric antral contractions decreased from 1 every 24 seconds to only 1 every 2½ minutes. Young and Sun[1c] found a similar effect. Moreover, their results in 7 patients indicated that Robanul, in a dose of 2 mg., did not produce delay in gastric emptying or intestinal transit.

What's the best dosage schedule for Robanul?

It should be adjusted for each patient, and this is where Robanul offers another big advantage. Its "titratability" is unmatched among anticholinergic agents. Robanul's potency makes possible a recommended starting dose of only one milligram t.i.d. Yet its selectivity usually permits much leeway for dosage adjustment upward as necessary, to achieve the most effective dose level for each patient while maintaining a low incidence of undesirable effects on other organ systems.

Is there anything else Robanul does for peptic ulcer?

Much more! For instance, 2 mg. cuts pepsin production about 50% in two hours; 4 mg., about 65%.[1a]...There is evidence that Robanul combats hormonal aspects of gastric secretions as well as vagal in many patients... ...Its activity lasts long enough to reduce acid secretion all night long.[3]...Many ulcer patients have remarked about its fast relief of pain....

One last question: Why not prescribe Robanul for your next duodenal ulcer patient and see for yourself just exactly how effective it is?

References: 1. From the New York Academy of Sciences, Conference on Peptic Ulcer, Oct., 1961. (a) H. C. Moeller. (b) D. C. H. Sun. (c) R. Young and D. C. H. Sun. 2. W. C. Breidenbach: Investigative clinical report, March, 1961. 3. I. A. Feder: Investigative clinical report, May, 1961.

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11.12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A. Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8.772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan, G. G.: Diseases of Metabolism, 4th edition, W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

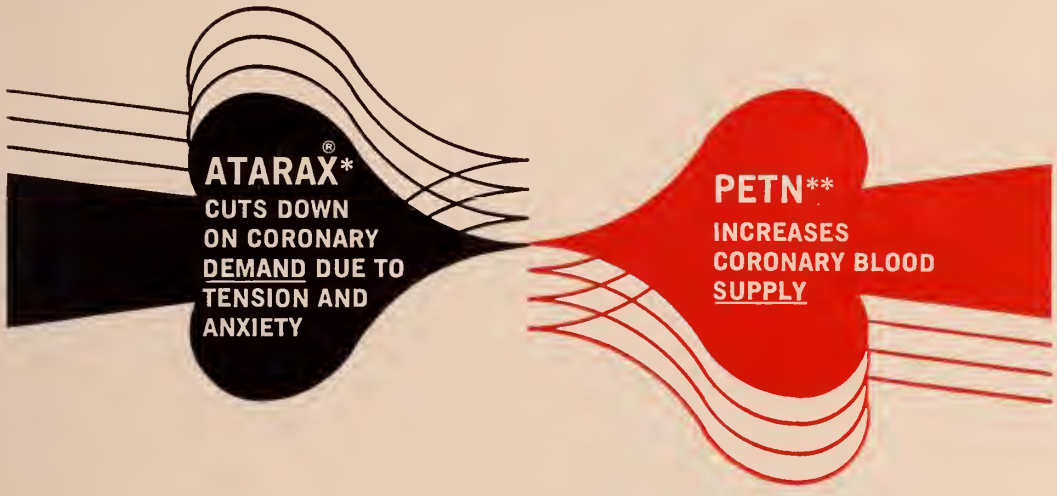
Available in bottles of 100 (Class B narcotic).

*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

Winthrop LABORATORIES
New York 18, N. Y.

HOW CARTRAX® OFFERS BETTER PROTECTION AGAINST ANGINA PECTORIS THAN VASODILATORS ALONE:



TOGETHER—IN CARTRAX...

they decrease "length, severity, and amount of angina pectoris" in anxious cardiacs.[1]

Give your angina patient better protection by balancing supply and demand...with CARTRAX.

note: Should be given with caution in glaucoma.

dosage: Begin with 1 to 2 yellow CARTRAX "10" tablets (10 mg. PETN plus 10 mg. Atarax) 3 to 4 times daily. When indicated, this may be increased by switching to pink CARTRAX "20" tablets (20 mg. PETN plus 10 mg. Atarax). For convenience, write "CARTRAX 10" or "CARTRAX 20."
Supplied in bottles of 100. Prescription only.

1. Clark, T. E., and Jochem, G. G.: Angiology **11**:361 (Aug.) 1960.

*brand of hydroxyzine **pentaerythritol tetranitrate

Roerig Rx

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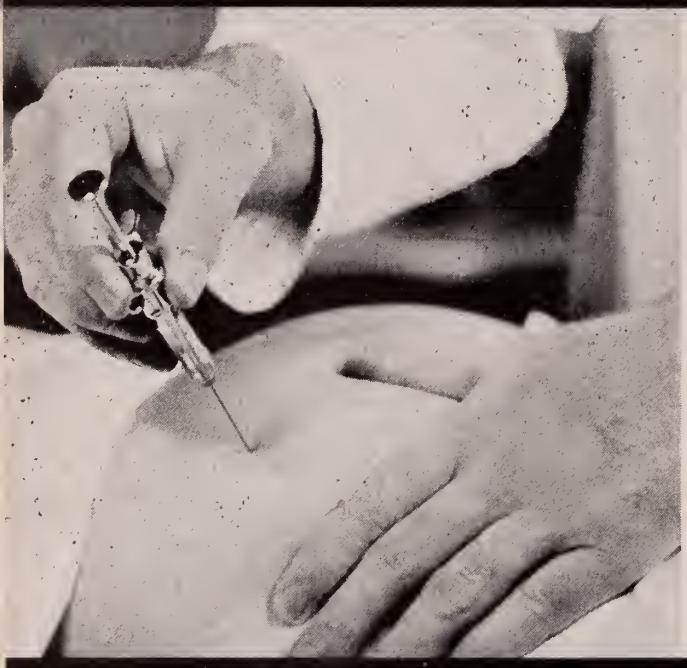
In oral penicillin therapy

COMPOCILLIN-VK

offers the speed, the certainty,

the effectiveness

of this...



with the safety

and the convenience

of this...



IN ORAL PENICILLIN THERAPY

COMPOCILLIN®-VK

POTASSIUM PENICILLIN V

BECAUSE potassium penicillin V (Compocillin-VK) offers excellent absorption[1,2,3,4]—fast, predictable levels of antibacterial activity enter the blood stream and quickly reach the site of infection. *Absorption takes place high in the digestive tract and is virtually unaffected by gastric media.*

Antibacterial levels are so predictable that, in many cases, *Compocillin-VK may be prescribed in place of injectable penicillin.* This is especially appreciated by younger patients and—as you know—oral administration is considered far safer than injectable.

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1. R. Lamb and E. S. Maclean, Penicillin V—A Clinical Assessment After One Year, *Brit. M. J.*, July 27, 1957, p. 191-193. 2. J. I. Burn, M. P. Curwen, R. G. Huntsman and R. A. Shooter, A Trial of Penicillin V, *Brit. M. J.*, July 27, 1957, p. 193. 3. J. Macleod, Current Therapeutics, *The Practitioner*, 178:486, April, 1957. 4. W. J. Martin, D. R. Nichols and F. R. Heilman, Observations on Clinical Use of Phenoxymethyl Penicillin (Penicillin V), *J.A.M.A.*, p. 928, March 17, 1956.

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IN FUNCTIONAL G.I. AND BILIARY DISTURBANCES ...TO EACH PATIENT ACCORDING TO THE NEED

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Hydrocholeretic • Antispasmodic • Sedative...to reduce *TENSION* and anxiety-induced dysfunction of G.I. and biliary tracts...and also relieve both smooth-muscle *spasm* and biliary/intestinal *stasis*

butabarbital sodium ..... 15 mg. (¼ gr.)
(Warning—may be habit forming)
dehydrocholic acid, AMES .....250 mg. (3¾ gr.)
belladonna extract ..... 10 mg. (⅙ gr.)

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Hydrocholeretic—Antispasmodic...to relax *SPASM* of smooth muscle of G.I. tract and sphincter of Oddi...and also counteract biliary/intestinal *stasis*

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belladonna extract ..... 10 mg. (⅙ gr.)

DECHOLIN®

Hydrocholeretic...to combat *STASIS* in bowel and biliary tract...by activating biliary function with a greatly increased flow of aqueous "therapeutic" bile

dehydrocholic acid, AMES .....250 mg. (3¾ gr.)

Average adult dose: 1 or, if necessary, 2 tablets three times daily.

Side effects: DECHOLIN by itself, or as an ingredient, may cause transitory diarrhea. Belladonna in DECHOLIN with Belladonna and DECHOLIN-BB may cause blurred vision and dryness of mouth.

Contraindications: Biliary tract obstruction, acute hepatitis, and (for DECHOLIN with Belladonna and DECHOLIN-BB) glaucoma.

Precautions: Periodically check patients on DECHOLIN with Belladonna and DECHOLIN-BB for increased intraocular pressure. Also observe patients on DECHOLIN-BB for evidence of barbiturate habituation or addiction, and warn drivers against any risk of drowsiness.

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Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

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Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.



"All the world's a stage..
And one man in his time
plays many parts,
His acts being seven ages..."*

*As You Like It, Act II, Sc. 7

through all seven ages of man

VISTARIL®

effective anxiety control with a wide margin of safety



in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

VISTARIL® CAPSULES AND ORAL SUSPENSION
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THIS END UP

Can we measure the patient's comfort?

The physician can measure the basal metabolic rate by means of oxygen consumption. But he has no instrument—no objective test—for measuring comfort.

For this, he must depend upon his own powers of observation and the patient's own description of how he feels.

Because these are, admittedly, subjective criteria, the validity of results hinges entirely on the experience and objectivity of the investigators involved.

Such well-qualified clinicians have reported that a new corticosteroid developed in the research laboratories of Upjohn actually raises the level of relief obtainable with this type of therapy.

This difference cannot be "proved." It must be seen. And the only practical way for you to do this is to evaluate this new drug critically in your own practice. Please do, at your first opportunity. We are confident that you will be glad you did.

The new corticosteroid from Upjohn research

Alphadrol*

Each tablet contains Alphadrol (fluprednisolone) 0.75 mg. or 1.5 mg.
Supplied in bottles of 25 and 100.

The anti-inflammatory activity of Alphadrol is comparable to the best effects obtained in current practice. Results obtained with Alphadrol have been such as to warrant classifying it among the most efficient steroids now available.

More than twice as potent as prednisolone, Alphadrol exhibits no new or bizarre side effects. Salt retention, edema or hypertension, potassium loss, anorexia, muscle weakness or muscle wasting, excessive appetite, abdominal cramping, or increased abdominal girth have not been a problem.

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The benefits of Alphadrol (anti-inflammatory, antiallergic, antirheumatic, antileukemic, antihemolytic) are indicated in acute rheumatic carditis, rheumatoid arthritis, asthma, hay fever and allergic disorders, dermatoses, blood dyscrasias, and ocular inflammatory disease involving the posterior segment.

Precautions and contraindications
Patients on Alphadrol will usually experience dramatic relief without developing such possible steroid side effects as gastrointestinal intolerance, weight gain or weight loss, edema, hypertension, acne or emotional imbalance.

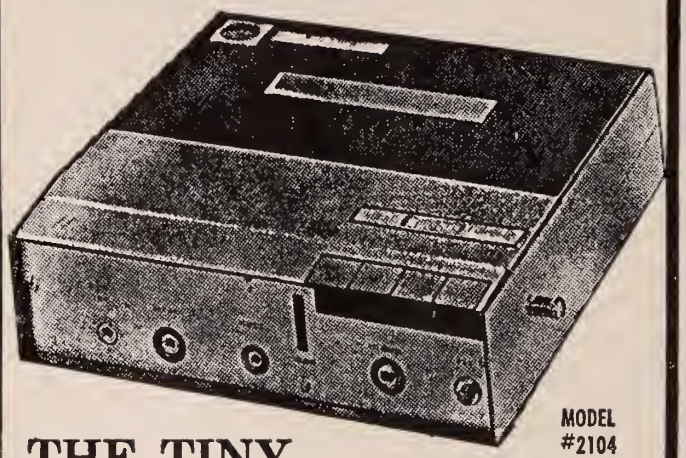
As in all corticotherapy, however, there are certain precautions to be observed. The presence of diabetes, osteoporosis, chronic psychotic reactions, predisposition to thrombophlebitis, hypertension, congestive heart failure, renal insufficiency, or active tuberculosis necessitates careful control in the use of steroids. Like all corticosteroids, Alphadrol is contraindicated in patients with arrested tuberculosis, peptic ulcer, acute psychoses, Cushing's syndrome, herpes simplex keratitis, vaccinia, or varicella.

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February, 1962

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Kalamazoo, Michigan

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So small it fits in the smallest briefcase with plenty of room left over! Wonderful for office, school or home, perfect as a gift that keeps on giving! Only 4½ pounds, 8" x 8" x 2½". Battery powered. Push Button controls. Two constant speeds, dual track; records and plays back one full hour on a 3" reel of tape. With mike, batteries and carrying strap. Gift Boxed.

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Form 1040—Symbolizing tension/anxiety caused by the ever-increasing cost of living.

allays tension/anxiety...maintains acuity... promotes eunoia* for cardiovascular patients

23 patients suffering from coronary artery disease and angina pectoris, arterial hypertension, and chronic rheumatic cardiovascular disease with mitral stenosis and insufficiency were treated with **LISTICA®**, 200 mg., t.i.d.[10]

"All 12 patients who had coronary artery thrombosis with angina pectoris decreased their daily use of nitroglycerin during **LISTICA** therapy. **LISTICA** proved to be helpful in maintaining a relaxed, less tense state in the remaining 8 cases of essential hypertension and in the three cases of chronic valvular disease due to rheumatic fever."[10]

During 3½ years' clinical study in thousands of patients with a variety of complaints, investigators have not reported any toxicity, habituation or contraindications, and none of the serious side effects increasingly reported with other drugs. Most frequent reaction (mild drowsiness in 38 cases) disappeared after the first few days. **LISTICA** therapy facilitates somatic diagnosis and treatment.

L I S T I C A®

THE FIRST SELECTIVE TENSITROPIC **ARMOUR PHARMACEUTICAL COMPANY · KANKAKEE, ILL.**

[1]Hubata, J. A., and Hecht, R. A.: Review of Clinical Use of Hydroxyphenamate (Listica) in 1,759 patients. To be published in Clinical Medicine; [2]Taub, S. J.: Management of Anxiety in Allergic Disorders—New Approach. To be published in Psychosomatics; [3]Cahn, B.: Experience with a New Tranquilizing Agent (Hydroxyphenamate). Ibid; [4]Bergal, M., Beck, C., Davis, O. F., and Sloan, N.: On Use of Hydroxyphenamate in Anxiety Associated with Somatic Disease. To be published; [5]Alexander, L.: Effect of Hydroxyphenamate on Conditional Psychogalvanic Reflex in Man. Supplement to Diseases of the Nervous System, Sept., 1961; [6]Cahn, B.: Effect of Hydroxyphenamate in Treatment of Mild and Moderate Anxiety States. Ibid; [7]Cahn, M. M., and Levy, E. J.: Use of Hydroxyphenamate (Listica) in Dermatological Therapy. Ibid; [8]Eisenberg, B. C.: Amelioration of Allergic Symptoms with a New Tranquilizer Drug (Listica). Ibid; [9]Friedman, A. P.: Pharmacological Approach to Treatment of Headache. Ibid; [10]Greenspan, E. B.: Use of Hydroxyphenamate in Some Forms of Cardiovascular Disease. Ibid; [11]Gouldman, C., Lunde, F., and Davis, J.: Clinical Trial of Hydroxyphenamate in Alcoholic Patients. Ibid; [12]McLaughlin, B. E., Harris, J., and Ryan, E.: Double Blind Study Involving "Listica," Chlordiazepoxide, and "Placebo" as Adjunct to Supportive Psychotherapy in Psychiatric Clinic. Ibid.

***eunoia**: A normal mental state (Stedman's Medical Dictionary).

LISTICA—Hydroxyphenamate, Armour.



Calms the Tense, Nervous Patient

in anxiety and depression

The outstanding effectiveness and safety with which Miltown calms tension and nervousness has been clinically authenticated by thousands of physicians during the past six years. This, undoubtedly, is one reason why meprobamate is still the most widely prescribed tranquilizer in the world.

Its response is predictable. It will not produce unpleasant surprises for either the patient or the physician. Small wonder that many physicians have awarded Miltown the status of a proven, dependable friend.

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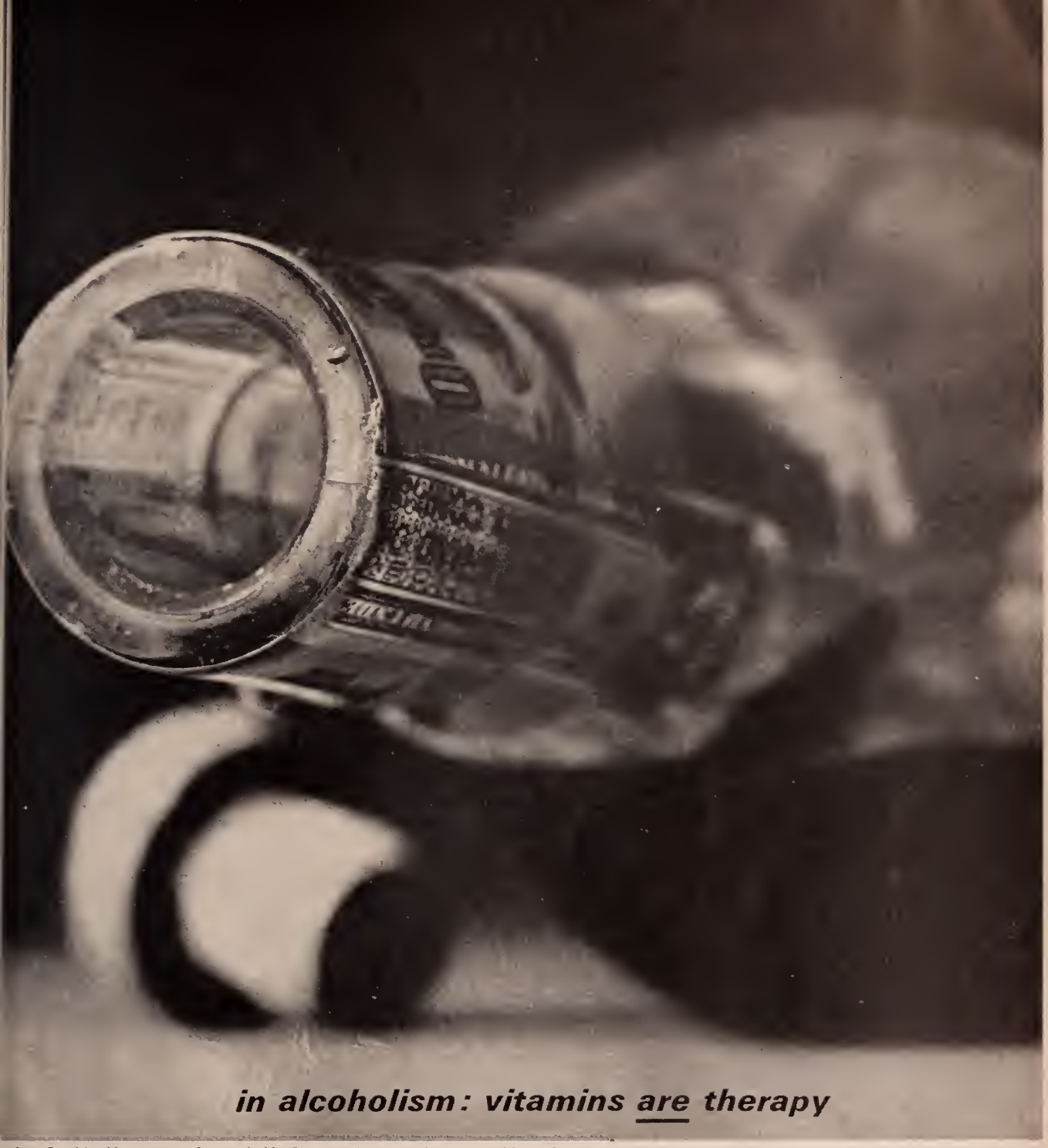
Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS®—400 mg. *unmarked*, coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

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Clinically proven in over 750 published studies

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Vitamin B_6 (Pyridoxine HCl)	2 m
Vitamin B_{12} Crystalline	4 mcgr
Calcium Pantothenate	20 m

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NEW comprehensive digestant with the *most potent* enzyme available for digestion of



—also unsurpassed potency for digestion of starch, protein and cellulose

—the *only* digestant with Lipancreatin,* proven superior to Pancreatin N.F.

—the *only* digestant with fat-splitting lipase activity 12 times as great as that of Pancreatin N.F.

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Dosage: 1 or 2 tablets with water just before each meal.

Supply: Bottles of 48 tablets.

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when "flu" strikes

relieve U. R. I. distress rapidly

- *relieve sneezing, runny nose*
- *ease aches and pains*
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For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, N. J.

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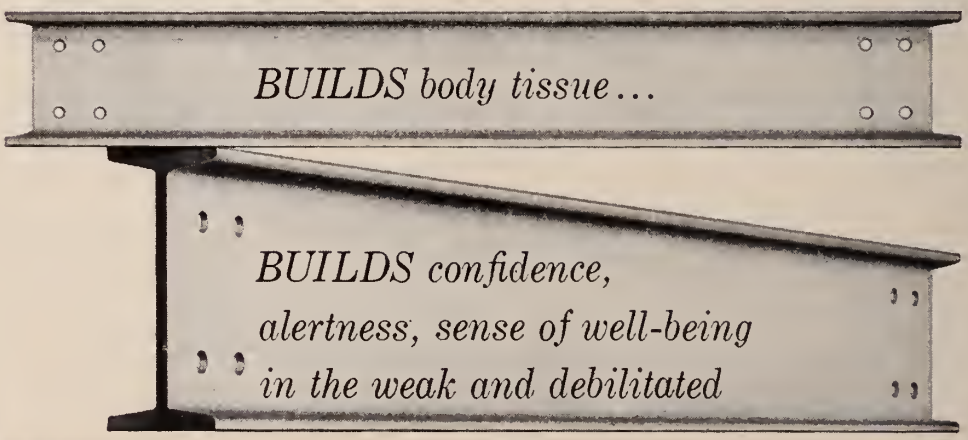
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- Marked improvement in appetite
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- Notable increase in vigor, strength and sense of well-being

for ...the tired, weak, irritable catabolic patient unable to overcome daily lethargy
...the elderly person with asthenia, inanition, anorexia or osteoporosis
...the patient with malignant, chronic or infectious disease
...the listless, undernourished child
...the adolescent with persistent underweight
...the patient on prolonged steroid therapy—to counteract catabolic effects

With WINSTROL, patients look better, feel stronger—because they are stronger.

Dosage: Usual adult dose, one 2 mg. tablet t.i.d. just before or with meals; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available in bottles of 100 tablets.

*animal data

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

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straight or concave?



If the confusing array of concentric circles were removed, it would be easy to see that the sides of the square are perfectly straight.

Likewise, when claims of "price" and "blood level" advantages are viewed in proper perspective, it becomes clear that it's what a drug *does* that counts.

V-Cillin K® achieves two to five times the serum levels of antibacterial activity (ABA) produced by oral penicillin G.[1] Moreover, it is highly stable in gastric acid and, therefore, more completely absorbed *even in the presence of food*. Your patient gets more dependable therapy for his money . . . and it's therapy he really needs.

For consistently dependable clinical results
prescribe V-Cillin K in scored tablets of 125 and 250 mg. or V-Cillin K, Pediatric, in 40 and 80-cc.-size packages. Each 5-cc. teaspoonful contains 125 mg. crystalline potassium penicillin V.

Lilly

V-Cillin K® (penicillin V potassium, Lilly)
1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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THE JOURNAL
OF
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Editorials • • •

Life Without Germs

For a long time it was believed that higher life could not exist without bacteria. In several research institutions now, studies are being made of the possibility of keeping animals alive and bacteriologically sterile. Here is how *Time* magazine (June 23, 1961) describes the technic:

"To get a germ-free line started, researchers have to deliver germ-free young by cesarean section. Just before the pregnant animal would normally deliver, it is anesthetized, strapped to an operating table, and its abdomen sterilized. Two sterilized tanks are connected by a sterile tunnel. The animal is slipped into the operating tank. A surgeon puts his hands in the rubber gauntlets sealed into portholes in the tank's sides. A set of sterile instruments is already in place. He delivers the young, drops them into a sterile tray, and passes them through the connecting tunnel into the rearing tank.

"Sterile air passes constantly through the rearing tank. A milk formula is slipped in through a sterile lock. Already inside are sterile eye droppers with rubber nipples. Every hour, 24 hours a day, the young animals must be fed by hand, always by the tedious process of working through a rubber gauntlet. Monkeys are the costliest animals to raise. Pigs are better: born with their eyes open, they are not a feeding problem, and when only six weeks old they are the right size for experimental surgery. Small animals such as rats, mice and guinea pigs will breed in the germ-free tanks, so that once the line has been established, generation after generation is born germ-free."

Using germ-free animals to study human ills, a research team headed by Dr. Walter L. Newton has found that the organisms that cause amoebic dysentery cannot survive in the bowel unless bacteria are present.

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But now comes the clincher. We are told that the Research Institute at Walter Reed Army Hospital has found that if germ-free guinea pigs are taken out of their sterile environment and put in an ordinary clean animal room, they all die of overwhelming infection within 96 hours.

The development of sterile environment may be valuable in surgery, since we still have to contend with the problem of wound infection.

But for the rest, it looks as if H. G. Wells' prediction in *The War of the Worlds* is true. Bacteria are our protectors as well as our enemies.

Sterility apparently is no more desirable bacteriologically than it is genetically.

Medicine Knows No Frontiers*

Every nation has contributed to medical progress. Every country has its quota of competent, dedicated doctors. To the physician all human beings are brothers and sisters, members of the same (human) race, children of the same God. This is a pretty sentiment, fine for a sermon or editorial. But do we really mean it? Can we do something to implement it?

Elsewhere in this issue* we publish an account of what is truly called New Jersey's unique project: the Ventnor Foundation. Here is this sentiment in action. And, as Mr. Snyder there says, it demonstrates that individual effort is not futile.

The international good will produced by this project cannot be measured. It has enormously added to the sense of fellowship in medicine. In its see-for-yourself, person-to-person approach, it contributes more to international amity than a dozen diplomatic conferences or beamed broadcasts. Furthermore, in a time of physician shortage, it has contributed the equivalent of a medical school graduating class: 60 top-of-the-class physicians—as house officers to the hospitals of (let us say, somewhat selfishly) our own state.

In medical educational circles in central Europe, the Ventnor Foundation has become a by-word. Curiously, it seems better known abroad than in its home state. Dr. and Mrs. Read have not sought—or obtained—much local publicity, because they did not want this set up as a personal project or used for their personal aggrandisement. This JOURNAL has respected their wish for privacy. However, the Executive Director of the Foundation was awarded the 1961 Brotherhood Award of the Brotherhood Council of Atlantic County; and the Verdienst Kreuz of the Federal Republic of (western) Germany. Other recent accolades have included an honorary Doctor of Science degree by Rutgers and another by the Medical Faculty of Cologne, in Western Germany. Dr. Read has also received the Philips Medal and New Jersey's unique Edward J. Ill award for his "contributions to education in democracy through medicine." Under the circumstances it would appear that the time has come when we in New Jersey should put on record our pride in this enterprise.

*See page 84.

Problems in Executive Health*

During the last decade, many management programs have adopted the annual health examination. How successful this has been is shown by the lowered mortality rate, the decline in time loss due to illness and the tangible profits accruing in improved efficiency and morale.

This is most striking in the area of emotional problems, for the modern executive is subjected to the stress of a demanding job and the strain of a competitive environment. To this atmosphere must be added his own hopes, worries, disappointments and family responsibilities. The contemporary world, is in many respects, a frustrating one. The feelings that produce tantrums in babies can be equally explosive in adults. Nowhere is this more notable than in management groups. For the very nature of their endeavor is to maintain calculated stability in the midst of constant alterations in the economic and social goals of their personal and business life.

Physical and emotional difficulties seem increasingly common in the late thirties and early forties. There are many reasons: (1) the sudden realization of physical deterioration, (2) diminishing sexual ability, (3) some small incident in the home or on the job that throws hopes or ambitions out of tune. The sudden "crack-up" experienced by many executives may have a long trail leading to it. We all travel the same path and the only thing that really smooths the way is the delicate balance between reality and our own character and philosophy.

Modern business puts great stress on teamwork and human relations. However well grounded in this field, the executive's attitudes and interpretations are based on a balance of knowledge and environmental growth. Defensive reactions developed at an early age may, under pressure, result in anxiety patterns. Insecurities are evidenced by the constant need for approval by others or the necessity of demonstrating superiority at all costs.

What motivated the man is, therefore, all-important to the organization. Desirable is an ingrained sociability and ease in relationship with others, the ability to surmount criticism and disagreement and the intelligence to plan and inspire success. In each case emotional balance is the vital key.

Taking at random one thousand executives examined by the New Jersey Executive Health Center, 56 per cent had "minor" undiagnosed ailments; 42 per cent "significant" impairments in mental or physical health; 2 per cent required immediate medical supervision and treatment. Average age was 43 years, 2 months. Considering the investment business had in these key men, and with ability in short supply, any health program which would help the executive help himself pays dividends to the company.

Tied to a desk, airplane, train, night club or conference room, today's executives get little regular exercise and build tension and pounds at an alarming rate. These factors bear directly on individual efficiency and administrative ability.

Every executive lives a Doctor Jekyll and Mr. Hyde existence between business and family. Few are outstandingly successful in fulfilling both roles. The seven to seven routine of management leaves many men so drained that they have little time or energy for family demands. Add to this picture the community activities which firms encourage and the executive is frequently more a visitor than a member of the household.

Generally speaking, there are two main classes of executives: (A) the mature, well-balanced leader who will attract and seek out brains and skill to complement his own endeavors; and (B) the talented but defensively insecure and immature personality who will tolerate about him only those individuals willing to subordinate their ideas and aspirations.

Both groups are important in the business world, and both live in an environment of compulsory productivity.

Faced with the growing shortage of capable replacements, American business is increasingly aware that a balanced program of health supervision and health education is the answer to survival and growth in management groups. An Executive Health Program will not eliminate the stress inherent in business. It can and does contribute to the health and environmental adaptability of the individual, as well as the business community.

ROBERT B. MARIN, M.D.

*Also see book review by Dr. Marin on page 106.

Local Autonomy and the Blues

". . . Blue Shield is sponsored and supported by physicians, *nationwide*. More and more *nationwide* corporations and *national* organizations are becoming interested in purchasing health insurance on a uniform, *nationwide* basis. But Blue Shield, at this moment, is not sufficiently equipped as a *national* movement to supply and service their need for *nationwide* health insurance coverage . . ."

The words are those of Carl Ackerman, M.D., Chairman of the Board of United Medical Service—New York's Blue Shield Plan—but the emphasis is ours.

Why have 69 autonomous local Blue Shield Plans failed to agree upon a marketable Blue Shield program for national accounts? Dr. Ackerman answers: "Each Plan," he says, "thinks its approach to the problem is best and allows for little give and take." He supports the principle of *local autonomy* for *local* problems; but he asserts that "the principle that concerns me is that Blue Shield continues to serve as a major mechanism to preserve for the public and the medical profession the freedom of the voluntary system of medical practice in this country."

Medicine's stake in Blue Shield is incalculable. It represents by far the largest underwriter of voluntary prepaid medical care. *It's the only program operated under the guidance and sponsorship of the medical profession* and committed to the free-choice, fee-for-service pattern of practice.

Give and take is the essence of survival. By giving a little, and adjusting the details of our local Plans to conform to the demands of the national market—always without compromising any important principle—we may save free medicine for our patients and ourselves.

The answer lies with us—for Blue Shield looks to us for guidance. And we must look to Blue Shield if we are to continue to be the masters in the house of medicine.

MORRIS A. ROBBINS, M.D.

Burlington

E. VERNON DAVIS, M.D.

Camden

Spinal Surgery

Results and Lessons from Eleven Years' Work in New Jersey*

The literature is heavy with statistics on people who say: "Oh, my aching back!" But here, in simple, common sense fashion, two New Jersey orthopedists show what actually happens in day-by-day practice.

IT HAS been our policy to treat orthopedic problems involving the spine non-operatively except when surgery is mandatory or when other generally accepted modalities have failed in a reasonable period of time. To test our indications for surgery we have collected follow-up data on all our surgical "backs" through 1958, from the time the senior author began his civilian orthopedic practice in 1948. That this paper may also serve as a guide to our younger orthopedic colleagues in planning their own courses, each consecutive operative back case, including scoliosis, has been included in this study.

Eighty spinal operations were done in 11 years. All were completed more than 2½ years ago at this writing. Pre-operative indications were as follows:

Herniated intervertebral disc: 29 cases or 36 per cent of the total.

Degenerative joint disease: (including apophyseal arthritis) 16 cases or 20 per cent of the total.

"Unstable back:" 9 cases or 11 per cent of the total.

Spondylolisthesis: 6 cases or 7½ per cent of the total.

Idiopathic scoliosis: 5 cases or 6 per cent of the total.

Pseudarthrosis from previous grafts done elsewhere: 3 cases or 4 per cent of the total.

Multiple congenital defects: 2 cases or 2½ per cent of the total.

One case each was seen of spina bifida occulta and arthritis, neoplasm (decompression and biopsy), paraplegia (decompression), other single congenital anomaly, fracture of articular process with non-union, fracture of vertebral body, nerve root pressure without herniated disc.

Tabulation of ages at operation is as follows:

10 to 19 years: 6 cases or 7½ per cent.
20 to 29 years: 6 cases or 7½ per cent.
30 to 39 years: 32 cases or 40 per cent.
40 to 49 years: 24 cases or 30 per cent.
50 to 59 years: 12 cases or 15 per cent.
None were operated at age 60 or older.

The three general types of pain associated with low back disease were distributed as follows: twenty-six cases (32½ per cent) with local back pain only; thirty-nine cases (49 per cent) with both local and referred pain; and nine cases (11 per cent) having referred

*From the Cooper Hospital in Camden and the Burlington County Hospital in Mt. Holly.

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pain only. The remaining six cases (7½ per cent) had no pain.

Duration of pre-operative pain varied considerably as follows:

Ten years or more: 11 cases or 14 per cent.
Five to nine years: 10 cases or 12½ per cent.
Two to four years: 12 cases or 15 per cent.
Six to eighteen months: 15 cases or 19 per cent.
Less than six months: 23 cases or 29 per cent.
No pain (scoliotics and fractured articular process case): 5 cases or 6 per cent.
Uncertain: 4 cases or 5 per cent.

Myelograms were done in nineteen cases (24 per cent). They were done only when mechanical nerve root pressure and/or obstruction was suspected. Seventeen (90 per cent of all myelograms) were positive. Subsequent disc removal was accomplished in ten patients with positive myelograms (59 per cent of positive myelograms). Herniated discs were *not* found in the remaining 41 per cent of patients with positive myelograms.

Our philosophy has been to fuse most disc cases when the patients are past their middle twenties. This should prevent the need for subsequent fusion. Combined laminectomy and fusion has been favored to the extent of thirty-six (45 per cent) of our back operations. When no exploration was indicated, we have performed fusion only in twenty-eight (35 per cent) of our cases. Laminectomy only accounts for ten (12½ per cent), while revision of fusions done elsewhere covers three cases (4 per cent). In the remaining three instances (4 per cent) the procedure was release of pressure and biopsy.

Pathologic discs have been removed in twelve patients, which amounts to 15 per cent of our back operations. Of these, there were an equal number having laminectomy alone and laminectomy and fusion.

COMPLICATIONS

Fourteen complications during hospitalization were directly attributable to the surgery; this represents 17½ per cent of our patients. Three patients (4 per cent of the eighty) developed wound infections. Two of these were subsequently cured under our supervision. One sought aid elsewhere. One of the 80 patients developed thrombophlebitis which subsided. Four patients (5 per cent) developed wound hematomas without infection. All were healed by evacuation of the blood. There has been only one hospital death (1.25 per cent). This resulted from a pulmonary embolism. One patient had an unusual amount of wound necrosis, but this healed satisfactorily. One patient each developed non-fatal pulmonary infarction, severe bladder infection, traumatic shock and blood loss and serratus anterior paralysis, all of which healed.

Six of the 80 patients had late post-hospitalization complications directly related to the surgery. Two patients had recurrence of their pains, both were subsequently cured conservatively. Two others failed to fuse well enough (pseudarthrosis). One eventually healed spontaneously; the other was re-operated elsewhere. One unhappy patient continued to have sciatic anesthesia. She committed suicide, but she also had porphyria with its severe mental aberrations. One person complained of scar tenderness for a long time but she finally improved. In the entire series (80 cases) there was only one transfusion reaction. This was not fatal.

Three patients died from coronary occlusion or malignancy. These deaths were not directly related to the surgery; they occurred following discharge from the hospital. One died from abdominal disease long after her back operation. Five per cent of our patients have died naturally.

Forty (50 per cent) of our patients were operated on from five to twelve years ago by the time this study was completed and the other forty were done 2½ to five years ago.

The following criteria have been used in the final evaluation of the results of surgery.

Excellent: The patient expressed complete satisfaction; or there was an exceptional functional improvement.

Good: There were no complaints; or the patient resumed his former occupation comfortably.

Fair: There were mild residual symptoms; or a major complication which healed.

Poor: There were continuing pre-operative symptoms or signs, mild draining sinus, pseudarthrosis or re-operation.

Failure: A severe complication persisted.

Using these criteria in reference to the cases operated five to twelve years ago, there are eight (10 per cent) rated *excellent;* eleven (13.75 per cent) *good;* two (2½ per cent) *fair;* three (3.75 per cent) *poor.* There was not one single failure, but we had one surgical death, three deaths from natural causes and twelve (15 per cent) with unknown results.

In those patients operated 2½ to five years ago, nine (11 per cent) are *excellent;* twenty-three (29 per cent) *good;* four (5 per cent) *fair;* two (2½ per cent) *poor;* no failures; no surgical deaths; one suicide, one natural death and one unknown result.

By "unknown" we mean those patients whom we have not seen for five or more years or whose follow-up period was too short for any other reason.

By eliminating all the unknowns from our total of eighty operations, we have sixty-eight cases in which adequate follow-ups have been made.

Thus, in the final analysis, results for all adequately studied patients operated 2½ to twelve years ago are as follows:

Excellent—17 cases—25 percent of sixty-eight total cases.
Good—34 cases—50 per cent.
Fair—6 cases—9 per cent.
Poor—5 cases—7 per cent.
Failure—none.
Died Surgically—1 case—1½ per cent.
Died Naturally—4 cases—6 per cent.

When only the five to twelve-year cases are included, we arrive at the following:

Excellent—8 cases—29 per cent of twenty-eight total cases.
Good—11 cases—39 per cent.
Fair—2 cases—7 per cent.
Poor—3 cases—11 per cent.
Failure—none.

The results rated "fair" came from the following circumstances:

1. Degenerative joint disease in a woman in her fifties who later developed central nervous system degeneration. This was undetected at the time of surgery but is always a possibility in patients of this age.

2. A traumatic paraplegic who was decompressed in an effort to aid him. Prognosis was guarded pre-operatively.

3. A young man with previous fusion done by another surgeon. These cases should be approached with caution and carefully evaluated before attempting another operation.

4. An unstable back from congenital defect in a neurotic who was not tagged as such before surgery. This is always a calculated risk in any patient.

5. Two disc cases, one with a positive myelogram and one without a myelogram, both young middle aged men, and both having pain only a few weeks before operation; one having laminectomy and fusion.

The poor results came about as follows:

1. One 59-year old man, for degenerative joint disease, who had his recurrence in two years and was found to have developed an excessive amount of bone around the fusion site. Perhaps this man was too old for a fusion.

2. One plain failure of fusion in a 44-year old woman. This was unpredictable and unexplained.

3. One wound infection in a 36-year old woman who became pregnant soon after discharge from the hospital and who continued to drain for several months. She was then cared for elsewhere.

4. One woman with classical disc pathology. This 40-year old had a provisional diagnosis of porphyria. She continued to have sensory defects and she committeed suicide. It is probably unwise to operate on the spine of a porphyric patient.

5. One 40-year old man who had intractable pain for seven months, with a negative myelogram. He was a "miserable" patient postoperatively (from a personality standpoint) and he managed to have "five more" operations elsewhere. He ended up in a mental institution.

The obvious disparity between "disc" diagnoses and discs removed at operation in our series is explained by changed postoperative diagnosis and by the fact that some were treated by fusion only.

Duration of pre-operative pain seemed to make no appreciable difference to the final results.

SUMMARY AND CONCLUSIONS

1. This paper presents an analysis of eighty consecutive spinal operations done during the senior author's orthopedic practice in the eleven year period ending in December 1958. All types of spinal surgery have been included to give the young orthopedic surgeon an idea of what he will encounter in practice. The final results are similar to the statistics published elsewhere. This will also serve to show the orthopedist what to expect from his efforts if he takes equal care with his indications for surgery.

2. Overall "excellent" and "good" results were obtained in 75 per cent of the operations attempted. In the analysis of known results after five to twelve years, 68 per cent were rated excellent or good. The attrition of the years has altered the results by only 7 per cent.

3. Immediate complications were encountered in fourteen (17½ per cent) of the patients. These were no different from those found in other branches of surgery, none being peculiar to spinal surgery; and none were incurable.

4. One patient in eighty died as a result of his operation. Pulmonary embolism is a hazard common to all types of surgery.

5. Six patients (7½ per cent) developed late complications directly attributable to the surgery. Of these, all eventually cured spontaneously except one who, re-operated on elsewhere, still complains of pain; and one who succumbed to the emotional aberrations of porphyria and commited suicide.

6. Herniated discs were found and removed in only 59 per cent of those cases having positive myelograms. All with positive indications were operated on. The myelogram has not been infallible in our experience.

7. Our work has taught us to be wary of re-operating upon younger patients who have had previous surgery and who still have a list of complaints. We have learned to be cautious about doing surgery on potential neurotics, on patients approaching sixty years of age, on patients with porphyria and on those with allegedly intractable pain who have no objective signs.

313 West Broad Street

EKG Interpretations by Telephone

Electronic Medical Systems, Inc., St. Paul, Minnesota, state that they now have a device for transmitting electrocardiograms by telephone. They have successfully transmitted from St. Paul a human EKG over a telephone message network to Kansas City. Transmission occurred over a distance of 500 miles while the patient was being monitored. Transmission distance has no effect on the fidelity of the EKG.

This may mean a new era for medicine. Using this new equipment, physicians should be able to participate in a high speed system for the collection and evaluation of EKG.

Hospitals and practitioners in towns and villages that cannot support the services of a cardiologist now use the mails to obtain EKG analyses. This procedure requires up to 4 days. Using the new equipment, however, these doctors will be able to telephone EKG traces to a trained interpreter at a central location for immediate analysis.

In less than five minutes, the interpreter can make an analysis and telephone his report to the inquiring doctor while the patient is still in the office.

Marvin C. Becker, M.D.
Newark

Clinical Experience with Triparanol*

Preliminary studies indicate that triparanol is an effective and non-toxic means for lowering serum cholesterol and for influencing atherosclerosis.

Triparanol* has been heralded as an opening wedge to the pharmacologic therapy of hypercholesterolemia and atherosclerosis. Some biochemists say [1] that triparanol* has made an important contribution toward the solution of some of the major problems of intermediary metabolism. If this were its only value, it will have served an important purpose.

There are multiple etiologic factors in the production of atherosclerosis, such as heredity, sex, race and economic and social influences. The role of cholesterol has not been completely established but the high incidence of atherosclerosis in patients with elevated cholesterol levels in diabetes mellitus and familial hypercholesterolemia is suggestive. The Framingham report [2] reveals that elevated serum cholesterol in non-obese normotensive males is associated with a six-fold increase in the risk of developing arteriosclerotic heart disease. This certainly adds further substance to the suggestion. The world-wide epidemiologic studies of Keys [3] reveal a relatively low incidence of coronary artery disease in populations with low concentrations of serum cholesterol. These and other studies in humans and experimental animals make it seem reasonable to treat hypercholesterolemia in the hope of affecting atherosclerosis.

Cholesterol *per se* has several roles. These include the formation of steroid hormones and bile acids and the metabolism of fat as an ancillary substance. Its level depends upon such factors as diet, endocrine function and energy expenditure. Because of its possible relationship to atherogenesis, the physician has looked for ways of reducing this substance. He has tried to diminish absorption of cholesterol. Among the diets that have been tried are those low in fat or diets in which unsaturated fats were substituted. Thus corn oil, linoleic acid, safflower oil, beta-sitosterols and other unsaturated oils have been used to accomplish this diminution of absorption. The physician has sought to increase the metabolism of cholesterol and perhaps the biliary excretion of cholesterol. For these he has tried estrogens, thyroid and recently, various thyroxin isomers.[4] Nicotinic acid in large doses has been used and has been effective by some unknown mechanism, at least up to now. All of these methods, however, have well-known drawbacks. Recently, attempts to produce a

*Triparanol available as MER/29® from The Wm. S. Merrell Co., Division of Richardson-Merrell Inc., Cincinnati 15, Ohio, was kindly supplied by Robert M. McMaster, M.D., Associate Director.

1. Bloch, K. E.: *Prog. Cardiovas. Disease,* 2:539 (1960).

2. Dawber, T. R., Moore, F. E. and Mann, G. V.: American Journal of Public Health, 47:4 (1957).

3. Keys, A.: Diet and the Epidemiology of Coronary Heart Disease. Journal of the American Medical Association, 164:1912 (1957).

4. Best, M. M. and Duncan, C. H.: "Comparative Effects of Thyroxin Analogs as Hypocholesterolemic Agents." The Council on Arteriosclerosis of the American Heart Association, St. Louis, 1960.

product that would inhibit the synthesis of cholesterol have resulted in the introduction of triparanol.* It appears from the studies of Blohm and MacKenzie,[5] Avigan, Steinberg, Thompson, and Mosettig,[6] Mobberly and Frantz[7] and Gould, Lilly, and Mitchell[8] that triparanol* inhibits endogenous cholesterol biosynthesis at the desmosterol stage, which is the last precursor before the formation of cholesterol.

This paper will present experience with 23 patients on this drug over a nine-month period to observe its effect on serum cholesterol and the clinical manifestations of atherosclerosis.

MATERIALS AND METHODS

TWENTY-THREE patients with hypercholesterolemia with pretreatment control cholesterols ranging from 296 to 497 milligrams per 100 milliliters were selected. The group included 13 males and 10 females with ages varying from 47 to 71. Seventeen patients had arteriosclerotic heart disease, twelve with angina; three had previous myocardial infarction without angina; one had rheumatic and arteriosclerotic heart disease with aortic stenosis and angina; five had essential hypercholesterolemia; two had diabetes mellitus with hypercholesterolemia. Associated findings were xanthelasma palpebrum in four patients, arteriosclerotic peripheral vascular disease in two and hypothyroidism in one. Most of these patients were well-known to the author and had been under his care for many years. "Baseline" serum cholesterol levels were the average of two or three determinations made by the same technician using the method of Pearson, Stern, and McGavack.[9] The daily dose of triparanol* was 250 milligrams to be taken before breakfast. No advice was given relative to change in diet, drinking or smoking habits or physical activity. Some patients had previously been on low fat diets and continued on them. Serum cholesterol was determined at least every month and run in duplicate in an attempt to get results within a 3 per cent error range.

Clinical evaluation of the patient was made at each visit. The angina was evaluated with especial reference to history, nitroglycerin consumed, and tolerance of effort. Electrocardiograms and exercise tolerance tests were made if necessary. The xanthelasma palpebrum as a clinical indicator of cholesterol deposition was followed. Drug safety was checked by urinalyses, blood counts and blood urea nitrogen determinations when indicated.

The length of the study at the time these figures were determined varied from three to nine months; the total number of patient-months was 113.

RESULTS

Effect on Serum Cholesterol: Figure 1 shows the effect of the triparanol* on the mean serum cholesterol levels in the 23 patients. The average level decreased about 13 per cent after one month of therapy and about 17 per cent after two months. During the next three months, the level averaged about the same as that at the end of the second month; but by the end of six months, the decrease was 18 per cent. There has been no indication of drug escape.

Effect on Atherosclerosis: Twelve of the seventeen patients with arteriosclerotic heart disease had angina pectoris. Of these twelve, four improved clinically, five were unchanged symptomatically and three complained of increased severity or frequency of attacks. One of the four patients who improved had worked in a service station and had apparently been markedly incapacitated by angina; but after about a month he was able to increase his work tolerance up to the point of changing tires. (Figure 2) In one patient there was evi-

5. Blohm, T. R. and MacKenzie, R. D.: Archives of Biochemistry, 85:245 (1959).

6. Avigan, J., Steinberg, D., Thompson, M. J. and Mosettig, E.: Archives of Biochemistry, 2:63 (1960).

7. Mobberly, M. L. and Frantz, I. D.: *Circulation*, 20:965 (1959).

8. Gould, R. G., Lilly, E. H. and Mitchell, V. E.: *Circulation*, 20:965 (1959).

9. Pearson, S., Stern, S. and McGavack, T. H.: Annals of Chemistry, 25:813 (1953).

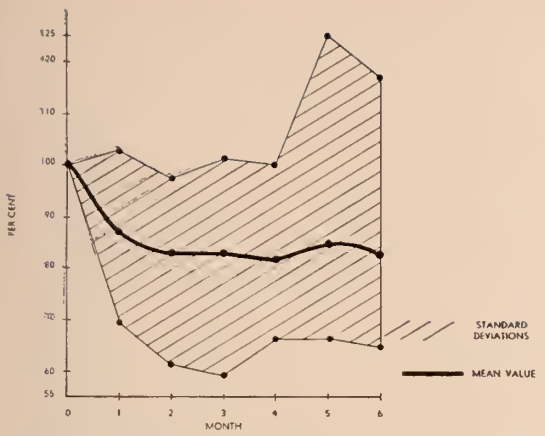


Figure 1. Effect of triparanol* on serum cholesterol of 23 patients. The average level decreased about 13 per cent after one month of therapy, 17 per cent after two months of therapy and 18 per cent by the end of six months. There is no evidence of drug escape. The rise at the fifth month is more apparent than real and reflects a rise in serum cholesterol in a patient who suffered a myocardial infarction and had discontinued the drug. (See Fig. 3)

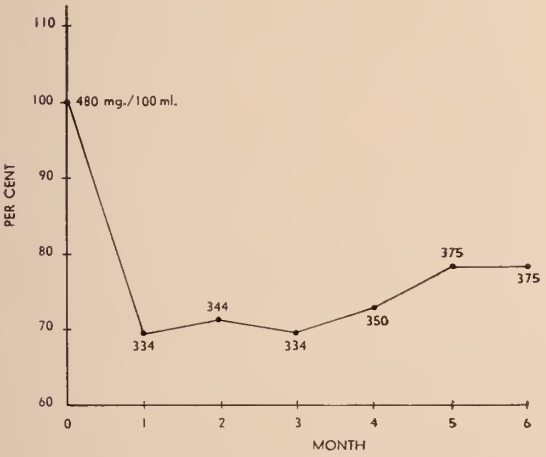


Figure 2. Serum cholesterol levels of a 56-year-old service station operator who experienced marked improvement in symptoms and work tolerance.

dence of resting and exercise electrocardiographic improvement. Two patients developed recurrence of myocardial infarction while taking the drug. (Figure 3) One of these (the patient with rheumatic and arteriosclerotic heart disease and aortic stenosis) died suddenly and the exact cause of death could not be determined.

Some improvement was seen in one of the four patients with xanthelasma palpebrum. In the two patients with peripheral vascular disease, no symptomatic or objective evidence of beneficial effect occurred.

Toxicity: Little evidence of toxicity was encountered. One patient noted transient peeling of the skin of the hands and another complained of impotence during his fourth to twelfth week on the drug. He then discontinued the medication, preferring that his cholesterol be elevated. In no patient was there evidence of renal and hematopoietic toxicity.

Since cholesterol is necessary for the synthesis of steroid hormones, it was felt that

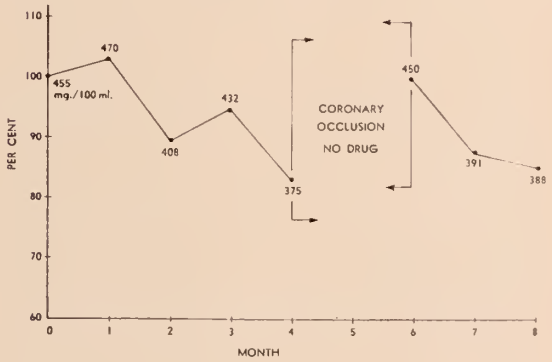


Figure 3. Effect of triparanol* on serum cholesterol of a 49-year old male who had arteriosclerotic heart disease with anginal syndrome and hypercholesterolemia. This patient developed an acute myocardial infarction during treatment. Note the rise in serum cholesterol to pretreatment levels in a two-month period, followed by adequate reduction.

a reduction in cholesterol might consequently reduce adrenal steroid production. None of the patients in this series had clinical evidence of adrenal insufficiency. In fact, no such case has been reported in the literature. Data have been cited [10] showing that there has been no decrease in urinary 17-ketosteroid excretion although some decrease in 17-hydroxycorticoids well within the normal range was noted.

10. Hollander, W. and Chobanian, A.: Boston Medical Quarterly, 10:37 (1959).

IN ANY discussion of the effect of a cholesteropenic agent on serum cholesterol levels it is important to try to establish what constitutes a "significant" drop. Ideally this would be a drop to normal non-atherogenic levels. However, there exists no exact definition of non-atherogenic levels. Without a definite guidepost, therefore, a standard must be chosen arbitrarily.

If a 10 per cent reduction of the average of all monthly serum cholesterols as compared with the "base-line" levels was chosen as "significant," then sixteen patients or 69.5 per cent of this group have shown a reduction greater than 10 per cent, with the average ranging from 13.7 to 35.5 per cent.

If, on the other hand, the *lowest* levels rather than the *mean* levels for each patient were chosen and a 20 per cent reduction assessed as "significant," then again sixteen patients or 69.5 per cent have had adequate serum cholesterol reduction. Ten patients, by this standard, had a reduction from 25 to 41 per cent below the base-line. In general the greatest decreases were among those patients with the highest base-line cholesterols, although no definite pattern could be determined.

These findings are in agreement with those reported in the literature. Hollander, Chobanian and Wilkins [11] noted that the serum cholesterol fell in about 80 per cent of the patients and reached a maximum in two to eight weeks.[12] It also took two to eight weeks to return to control level when the drug was stopped. The general feeling was that the longer the level was kept down, the longer it took to return to the control level. In an attempt to determine whether a decrease in serum cholesterol might be caused by a shift of the cholesterol out of the blood stream into the tissues or perhaps be due to a reduction of the body content of cholesterol, they did radioisotope studies and determined that the total miscible pool of cholesterol and total steroids were reduced significantly on triparanol,* suggesting, therefore, that the drug is effective in reducing both serum and body cholesterol. This might be an important finding if it were clearly demonstrated that cholesterol in the blood stream and that in the vessel wall are freely exchangeable. These studies are imperative.[13]

THE work of Rosenman and Friedman [14] and Friedman, Rosenman and Carroll [15] has raised the question of spontaneous fluctuation of serum cholesterol levels. In a study of 40 tax accountants in whom the serum cholesterol was determined bi-weekly for six months, they noted a difference between maximum and minimum levels averaging 64 milligrams per 100 milliliters with some fluctuations over 100. These data and others [16] revealing spontaneous cholesterol fluctuation make the problem evaluation more difficult. In this series, patients with wide variation in controls were not used. Apparently some patients are cholesterol-stable and others are cholesterol-labile. Most of the patients in this series had been known to be cholesterol-stable for years.

Weight reduction may also be accompanied by lower serum cholesterol levels but no significant weight reductions were noted in this series.

In consideration of the relation between triparanol* dose and serum cholesterol effect it is important to note the work of Lisan, Oaks, and Moyer.[17] A dose of 250 milligrams per day of triparanol* produced a slight drop after two weeks and a significant drop after one month of therapy. They found further that with a Gram a day there was a more precipitous drop, but that after a period of two to three months it made no difference which dose was administered.

11. Hollander, W., Chobanian, A. V. and Wilkins, R. W.: *Prog. Cardiovas. Disease,* 2:637 (1960).
12. Hollander, W., Chobanian, A. V. and Wilkins, R. W.: Journal of the American Medical Association, 174:5 (1960).
13. Editorial: Journal of the American Medical Association, 174:66 (1960).
14. Rosenman, R. H. and Friedman, M.: *Prog. Cardiovas. Disease,* 2:605 (1960).
15. Friedman, M., Rosenman, R. H. and Carroll, V.: *Circulation,* 17:852 (1958).
16. Kurland, G. S. and Freedberg, A. S.: *Circulation,* 22:464 (1960).
17. Lisan, P., Oaks, W. and Moyer, J. H.: American Journal of Cardiology, 6:246 (1960).

Blohm, Kariya, Laughlin, and Palopoli [18] have presented evidence that the cholesterol content of the arterial wall in animals is reduced with triparanol.* Such evidence would of course be difficult to obtain in humans. It is hoped, however, that reversal of cholesterol deposition might be obtained and in this way the problem of atherosclerosis with its resultant toll might be solved. Clinicians have tried indirectly to show this effect of triparanol* by evaluation of angina, reversal of electrocardiograms and improvement of exercise tolerance tests. The author studied these parameters, fully aware of the difficulty in the evaluation of anginal symptoms and of the facts that changes in electrocardiograms with reversion toward normalcy are often the result of the normal evolution of the disease and that exercise tolerance tests as evidence of improvement in coronary artery disease have certain pitfalls. In addition, the four patients with xanthelasma palpebrum were examined with the hope that demonstrable changes in this cholesterol-laden lesion might occur.

THE results of this study are in accord with those in the literature. Kountz [19] expressed enthusiasm for the compound in a study of 103 patients. Corcoran, Zimmerman, and Cuturelli [20] reported five patients with depression of serum cholesterol, improvement in effort tolerance and in resting electrocardiograms in addition to an improved sense of well-being. Halperin [21] also noted a large number of patients who had a good clinical response but felt that it could not be attributed to the hypocholesterolemic response of the drug; the clinical changes usually took place within a two-week period and the cholesterol had not reached the lowest levels at that time. Russek [22] noted no clinical improvement in 40 patients. Using the exercise tolerance test in 14 of these patients he also noted no improvement.

Hollander, Chobanian, and Wilkins [12] recently noted a clinical reduction in angina in 12 of 28 patients on triparanol. In 11 patients subjected to an exercise tolerance test because of reproducibility of response they noted an improvement in three. Lisan [23] in a study of 55 patients noted that angina improved in 14 of 16 patients with this complaint and revealed that several patients stated that intermittent claudication improved. Electrocardiographic studies generally showed no improvement except in one patient in whom a persistent ST depression pattern reverted to normal. In his series, two patients had a recurrence of coronary thrombosis. Their cholesterol levels had shown a marked drop followed by a sudden elevation. This phenomenon was not observed in this study.

Oaks [24] has noted occasional nausea, anorexia, temporary itching and a transient rash, and in liver function tests some increase in bromsulphalein retention was occasionally noted. Yet, Ruskin [25] in the most extensive study on this subject, with 30 patients over a four to ten-month period, reported that all liver function and enzyme tests were negative.

Because of the chemical relationship of triparanol to estrogen, it was assumed that perhaps the impotence in the one patient reported was due to an estrogen effect. Others have noted an occasional decrease in libido.[19] Kountz [19] reported one post-menopausal female with vaginal bleeding whose vaginal cytology revealed a mild estrogenic effect. Blohm [26] explains this by suggesting that although the drug itself is not estrogenic, it may slightly potentiate estrogen that is already present in the body. It is interesting to note that Toro [27] reported growth of hair in two balding females while on the drug. Unfortunately this did not happen to the balding males in this series.

18. Blohm, T. R., Kariya, T., Laughlin, M. and Palopoli, F.: *Fed. Proc.*, 18:369 (1959).
19. Kountz, W. B.: *Prog. Cardiovas. Disease*, 2:541 (1960).
20. Corcoran, A. C., Zimmerman, H. A. and Cuturelli, R.: *Prog. Cardiovas. Disease*, 2:576 (1960).
21. Halperin, M. H.: *Prog. Cardiovas. Disease*, 2:631 (1960).
22. Russek, H. I.: *Prog. Cardiovas. Disease*, 2:578 (1960).
23. Lisan, P.: *Prog. Cardiovas. Disease*, 2:618, (1960).
24. Oaks, W. W.: *Prog. Cardiovas. Disease*, 2:612 (1960).
25. Ruskin, A.: Archives of Internal Medicine, 106:803 (1960).
26. Blohm, T. R.: *Prog. Cardiovas. Disease*, 2:563 (1960).
27. Toro, J.: *Prog. Cardiovas. Disease*, 2:544 (1960).

It can be seen from this present series of patients and the existing literature that there are variable degrees of enthusiasm for triparanol* and for anticholesterol therapy in general. This probably comes from the very nature of atherosclerosis—a disease which ordinarily takes years to develop to the clinical stages and the pathogenesis of which is not clearly defined. It is too early to know the whole truth. To obtain this, cooperative studies by many investigators over long periods of time, under controlled conditions, will have to be done.

SUMMARY

1. Twenty-three patients with hypercholesterolemia were treated with triparanol (MER/29®) in an attempt to evaluate its ability to lower serum cholesterol and influence the course of atherosclerosis.

2. The drug is a simple, effective, nontoxic, convenient means of lowering serum cholesterol in approximately 70 per cent of patients and offers another therapeutic tool for the treatment of hypercholesterolemia.

3. Triparanol* is recommended in those patients with signs and symptoms of atherosclerosis or a family history of coronary artery disease, in whom cholesterol levels are significantly elevated and where dietary therapy has been unsatisfactory.

4. The influence of triparanol* on atherosclerosis, with coronary artery disease as an indicator, cannot be determined definitely from this study but some of the interesting results offer promise and warrant its further use.

299 Clinton Avenue

Rebound Tumbling Can Be Dangerous

Writing in the November 1960 Journal of the American Medical Association, William G. Ellis points out that rebound tumbling can cause fatal injuries. The most dangerous place on the canvas, he says, is the center. "Here occur injuries from acute flexion of the cervical spine."

Ellis reports 5 severe spinal cord injuries resulting from rebound tumbling. Three developed paralysis of both arms and both legs. The maneuver that led to the accident in four instances was the backward somersault. Two accidents occurred in a well-equipped university gymnasium under direct supervision of trained personnel.

The fatality involved a 19-year old, who did an elementary back drop, landing on his shoulders and back. He immediately became numb and paralyzed in his arms and legs. He had dislocation of a vertebra and died 14 days later.

In another case, a 38-year-old man attempted a backward somersault, landed on his head and shoulders and became paralyzed in his arms and legs.

A similar paralyzing effect occurred in a 17-year-old boy who failed to complete a backward somersault and landed on the back of his neck. The accident happened after he had been working out for eight hours. "The chief hazard lies in attempting difficult gymnastics feats before mastering the fundamentals.

"Attempts at somersaulting, both backward and forward, are the most dangerous maneuvers. Ten hours . . . is a minimum training period before somersaulting should be attempted."

The author urged local departments of health to establish minimum regulations concerning rebound tumbling centers.

Jose Vilanova, M.D.
Cedar Grove

The Use of Methandrostenolone (Dianabol®) in Improving Nutrition in Geriatric Patients†

Every doctor has to practice geriatrics these days. Nutritional problems are a major challenge. If Dr. Vilanova's experience is confirmed, it would appear possible to improve nutrition with a safe and simple anabolic agent.

In the care of geriatric patients, one of the most difficult challenges facing the physician daily is the dietary problem. This is especially true when the patient is in a senile psychiatric ward. In treating these patients, the physician rarely experiences any medical satisfaction. In the majority of the cases one finds only disappointment in maintaining proper nutrition.

Sebrell[1] says that, "Nutritional problems are usually more difficult to handle in the aged than any other group." Among the factors to be considered in attaining adequate nourishment are: (1) a decrease in metabolic and motor activity which reduces caloric requirements; (2) changes in secretions of endocrine and gastric fluids and diminishing rate of absorption; (3) appetite alterations because of disturbances in sight, smell, and taste;[2] (4) the tendency of many aged people to become argumentative about demanding spices and salt which usually are restricted in the diet; (5) the absence of teeth or the wearing of defective dentures, which together with the diminution of saliva and gastric juices, lead to gastric disturbances. These, plus diminishing muscular tonus, may bring about constipation and the resultant abuse of laxatives. Other factors frequently present in elderly persons are diabetes, fever, hepatic and renal dysfunctions, anemia, hypochlorhydria and achlorhydria. The endocrine glands, including the hypophysis, thyroid, adrenals, testicles, and ovaries, decrease in both size and function.[3]

Kountz[4] offers two principal reasons why this age group develops protein deficiencies. First, with advancing years the food intake is usually decreased. Foods which supply body-building proteins are most likely to be eliminated from the diet. Second, the body is less able to utilize protein after middle age.

All these problems are greatly increased in the senile wards of the psychiatric hospital. In addition to the previously mentioned factors, one must allow for the mental status of these patients, for their inability to follow orders,

†This work is from the Essex County Overbrook Hospital, Cedar Grove, N. J.

1. Sebrell, W. H.: in E. J. Stieglitz' Geriatric Medicine. Saunders, 1949, Philadelphia (Ed. 2) Page 187.

2. Thewlis, M. W.: The Care of the Aged. Mosby 1946, St. Louis (Ed. 5) Page 122.

3. Davis, N. S.: in E. J. Stieglitz' Geriatric Medicine. Saunders, 1949, Philadelphia (Ed. 2) Page 247.

4. Kountz, W. B.: in Cowdry's Problem of Aging. Williams and Wilkins, 1952, Baltimore (Ed. 3) Page 901.

for their deterioration, and, in many cases, their incapacity to eat by themselves because of motor and sensory deficiencies.

Kenyon[5] has demonstrated the anabolic properties of testosterone in promoting the formation of protein tissue. Since then, further study has shown the value of anabolic agents in the rehabilitation of the undernourished patient. Loss of weight is naturally the most obvious manifestation of malnutrition. In general, weight loss below ten per cent of the calculated body weight may be considered evidence of actual protein deficiency.[6]

New anabolic agents with less androgenic side effects have been synthesized. Methandrostenolone* (Dianabol®) is a new compound which possesses only one per cent of the androgenic potency of testosterone.[7] Previous studies have shown that in patients who were underweight in spite of an adequate caloric intake, anabolic agents have shown gratifying results.[8]

MATERIALS AND METHODS

With these concepts in mind, 42 patients were selected from male and female psychiatric wards, the common denominator being underweight. Their physical conditions were fair. Their mental conditions indicated a chronic brain syndrome with psychotic reaction; years ago some were originally diagnosed as "dementia praecox." All but two of the patients were ambulatory. Most of them could feed themselves. Neither the personnel in charge nor the patients were made aware of the type of medication to be used or the results expected from it. However, ample information was given about the possible side effects, and every change in appetite was meticulously noted. As Stieglitz[9] has said: "Appetite is variable; in true senility it is often greatly depressed."

These 42 patients (11 of them females) were then placed on Dianabol.® Routine laboratory studies were within normal limits. Their ages ranged from 38 to 86 years, with a predominance in the 60 to 70 years. (Figure 1) Dosage was the same for every patient—10 milligrams daily. The first group, consisting of the eleven female patients only, received a divided dose of 5 milligrams twice a day for a period of four weeks. The male group was on the medication for a period of five to six weeks. Blood pressures were recorded on the first day and at one-week intervals thereafter. Patients were closely observed for side effects or complications. Neither the patients nor the personnel were instructed on the effects of the drug, but they were advised to observe possible side effects.

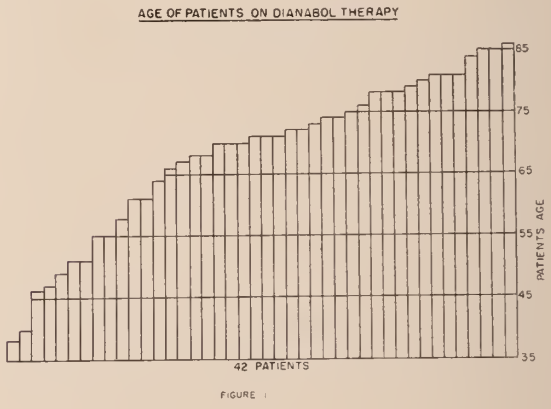


FIGURE 1

RESULTS

After four weeks, results were evaluated in the first group. Eight of the 11 female patients showed an increase in weight, ranging from 8 ounces to 2 pounds. Two remained at the same weight throughout the study, and one patient lost weight. (See Table 1) None presented side effects or complications.

Since the mental status of these patients had the common factors of confusion and deterioration, subjective feelings are difficult to evaluate, but it was clear that some showed im-

5. Kenyon, A. T.: *Biochemical Symposia,* 9:11 (1942).

6. Youman, J. B.: in Cecil and Loeb's Textbook of Medicine. Saunders, 1959, Philadelphia (Ed. 10) Page 535.

7. Desaulles, P., Kraembulh, C., Schuler, W. and Bein, H.: Schweize Medizinsche Wochenschrift, 89:1313 (1959).

8. Gordon, G. S.: *GP,* 10:87 (1954).

9. Stieglitz, E. J.: Geriatric Medicine. Saunders, 1949, Philadelphia (Ed. 2) Page 34.

TABLE 1.

WEIGHT CHANGES ON DIANABOL THERAPY

	Gain	Loss	No Change
Female	8	1	2
Male	25	1	5
TOTAL	33	2	7

provement in appetite. Those who required spoon feeding were less resistant when being fed.

The second group, 31 male patients, with the same characteristics in age, physical condition, and mental make-up, were studied for a longer time. Of these 31 patients, 25 showed a gain in weight of between 1 and 12 pounds. Weight remained the same in 5 patients. One patient lost weight. (See Table 1) In 3 of these 5 cases, upper respiratory infection, pneumonia, and skin infections contributed to the lack of response to therapy. In the other two cases, no explanation could be found.

The individual weight gains are charted in Figure 2.

CONTROL GROUP

DURING the same period, a control group of patients of similar physical and mental condition were evaluated in relation to their weight. This series of 34 males and 7 females had the following results: of the 34 males, 22 lost weight, 6 remained the same, and 6 showed a gain in weight. Of the 7 females in the control group, 3 lost and 4 gained weight. (See Table 2 below) The variations were between 1 and 12 pounds loss and the gain between 1 and 6 pounds.

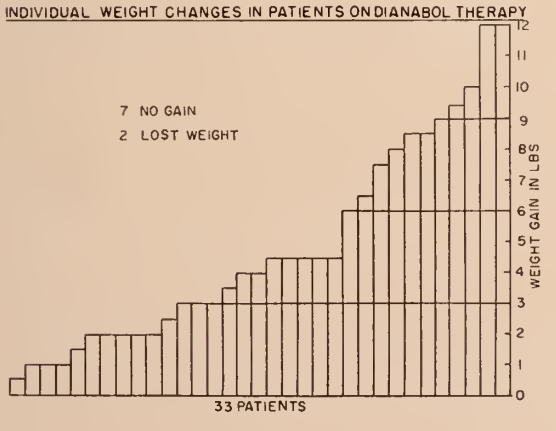


FIGURE 2

TABLE 2.

WEIGHT CHANGES IN CONTROL GROUP WITHOUT MEDICATION

	Loss	Gain	No Change
Males	22	6	6
Females	3	4	0
TOTAL	25	10	6

Six months after the drug was discontinued, a comparative study of 24 of the original 42 patients was made. Because of transfers, discharges, passes, and leaves, it was impossible to study more than these 24. Of these 17 showed a weight loss, 2 remained the same, and 5 showed a weight increase. (See Table 3)

TABLE 3.

WEIGHT CHANGES SIX MONTHS AFTER DIANABOL THERAPY DISCONTINUED

	No. of Patients
Lost weight	17
Gained weight	5
No change	2
TOTAL	24

SUMMARY

A NEW anabolic agent, methandrostenolone* (Dianabol®) was given to 42 underweight patients on the geriatric wards of a mental hospital. In females, the dosage was 10 milligrams daily for four weeks. Males received the same dose for a period of 5 to 6 weeks. A weight gain was observed in 33 (79 per cent) of the patients. Average increase in

*Methandrostenolone supplied as Dianabol® by CIBA Pharmaceutical Products Inc.

weight was 5 pounds per patient; loss of weight was reported in 2 cases; no change occurred in 7. During the study no untoward side effects or complications were encountered. No urinary retention, changes in blood pressure, or uncomfortable feelings were reported.

In a control series of patients, 61 per cent lost weight during a similar observation period on the same wards.

Methandrostenolone (Dianabol®) would thus seem to be a safe and effective anabolic agent in improving the nutritional status of undernourished patients.

1 Bolton Road

Frozen Baby Food

Concentrated dry frozen baby food has received the approval of three medical researchers reporting in the January 1961 American Journal of Diseases of Children. Drs. Gerard J. Van Leeuwen, Emily J. Guyer, and Robert L. Jackson, University of Missouri, reported on a study in which a variety of the frozen concentrated foods were fed to 49 infants.

"The food was accepted by all infants in the study and was preferred by mothers who had had experience with other strained foods," they said.

"None of the infants developed diarrhea, constipation, or allergic manifestations as a result of ingestion of the food. All the mothers stated that this new baby food appeared fresher and more appetizing. All preferred this new product with respect to ease of preparation and storage. Most mothers agreed that the small packages of frozen foods allowed them to feed a greater variety of foods to their babies."

The babies were started on the frozen foods at four months. Also three infants born prematurely were given the frozen foods and their growth was satisfactory.

At six months, most of the infants were taking about 1½ units of the frozen food, the equivalent of 8 to 12 ounces of strained foods.

The processing by which these foods are prepared include the limited application of heat, reduction of moisture, and freezing, the researchers explained. No added colors, flavors, preservatives, or fortifying nutrients are used in the process, they added.

Studies at the Wisconsin Alumni Research Foundation indicated that nutrients were effectively retained in processing and in storage at freezing temperatures, the authors also reported.

Bacteriologic studies at the University of Chicago showed that no food poisoning organisms were found in any of the specimens. The frozen food could be stored safely in a deep freeze for about one year and in a refrigerator for one month.

Do You Practice Propetology?

Writing in the September 1961 American Journal of Medicine, Williams and Siegel suggest that physicians should develop the study of proneness towards certain diseases. They offer the word *propetology* for a new science "which will deal with innate susceptibility and resistance primarily to diseases of a noninfective nature." Many diseases have genetic roots. The term, taken from the Greek *propet*, "leaning toward," emphasizes that people "merely lean toward certain diseases; it is by no means inevitable that they will contract them." People who are prone to certain diseases "would not need to suffer from these diseases if their proneness were recognized early and if appropriate measures could be taken to overcome it."

Henry Harris Perlman, M.D.

Philadelphia, Pa.

Dermatologic Problems in Pediatrics*

Diagnosis and Management Based on Histopathology

Anyone can memorize a list of dermatologic medicaments. But as Dr. Perlman here points out, an understanding of the basic histology and pathology will lead to understanding—without which therapy cannot be logical or effective.

The management of skin disorders in infants and children requires that the therapist have some general understanding of the more common histopathologic disturbances and of basic pharmacodynamics. The physician should know the composition of the remedies he prescribes, their indications and contra-indications, how best they can be ordered and the proper times for their use. For an example, an ointment useful for the chronic lichenified stage of atopic dermatitis may, by occluding the pilosebaceous openings during the *acute* exudative stage, trap the abnormal edematous fluid present in the epidermis and corium and thus worsen the condition that it is meant to alleviate. The same preparation employed correctly during the *chronic* stage may serve usefully in returning a sick skin to its normal equilibrium. The commonest liability of the sort occurs in ordering topical medication for the young. The so-called "therapeutic dermatitis" (contact dermatitis) is often brought about through the indiscrete use of remedial agents, both "official" and proprietary.

In the management of dermatoses in infants and children, two basic rules must be observed strictly if untoward effects are to be avoided. The first is: the more acute the inflammation of the skin, the milder the therapy; and the second: all topical medicaments should, in the beginning, be ordered in their mildest concentration and increased only as a tolerance for the remedy is developed by the skin. The physician's ability to become a sound dermatologic diagnostician and therapist requires years of experience; but the most important thing is for the practitioner to have an understanding of the underlying histopathology: of the process taking place in the living tissues of the skin. It is these changes, in the epidermis, corium and the subcutaneous layers, which produce the signs and symptoms composing the clinical picture of a characteristic dermatosis and it is these hidden but operative changes that will dictate the choice of remedial agents.

Allergic Eczematous Contact Dermatitis

We often see poison ivy dermatitis and poison sumac dermatitis here in the Eastern United States. Poison oak dermatitis is more often met along the west coast. All three of these varieties of *rhus*, however, are dependent upon a catechol-like derivative, a dihydroxyphenol which constitutes the active principle of the *rhus* plant: toxicodendric acid (toxicondenrol). This toxicodendric acid is both

*Presented May 17, 1961 at the Annual Meeting of The Medical Society of New Jersey in Atlantic City. The paper was illustrated by 45 lantern slides, not here reproduced.

a powerful irritant to the skin and a strong sensitizer. When the acid contained in the *rhus* plant has once anchored itself to the protein cells in the epidermis, there seems to be nothing that will dislodge it from the tissue.

The diagnosis of poison ivy dermatitis is comparatively simple, especially since there is usually direct evidence that the patient has been in contact with the ivy. However, a direct history of exposure is not always obtained. Remembering that the active principles of the ivy plant are skin irritants, the doctor should search for the effect of a severe irritant on the skin. This will appear as an acute redness not unlike that of erysipelas (due to a dilatation and engorgement of the capillaries in the upper corium with red blood cells). This will be soon followed by swelling of the skin of the face, eyelids and ears so that at the height of the inflammation the eyelids are swollen and closed; and this appearance, together with the severe edema of the rest of the face, gives an impression of formlessness like a jelly-fish, although the tip of nose protrudes like a spout. Clusters of vesicles—or vesicles in straight lines are another indication of the edema in the epidermis. Occasionally one sees bullae, and these lesions, together with papules and the linear configuration of the vesicles or papules (the Koebner phenomenon), make the clinical picture of *rhus* dermatitis unmistakable. While most of the lesions appear on the exposed areas of the body, the regions covered by clothing may also be affected. Pruritus, which is invariably present, can be quite severe.

The therapeutic indications are to relieve the itching, to remove the edematous fluid from the epidermis, to eliminate or minimize the heat and a burning sensation of the skin, and, in short, to restore the sick skin to normal. Itching usually responds to continuous wet dressings and to antiphlogistic topical remedies. The cortico-steroids by mouth are helpful antipruritic agents. Continuous wet dressings facilitate drainage of the edematous fluid from the epidermis and relieve the heat and discomfort of the affected skin. They may be administered as ice-cold preparations provided that their use is limited to small areas at a time.

Of the many wet dressings, I have found aluminum acetate solution (Burow's Solution) to be serviceable when diluted with water, 1 to 10 parts for the child and 1 to 20 parts for the infant. "Continuous wet dressings" denote exactly what these terms state: the solution is to be applied to the lesions through a Turkish towel and left in place more or less continuously for a period varying from 24 to 72 hours. Do not allow the wet dressings to interfere with the patient's rest and nutrition.

Another useful wet dressing is provided by the little daisy belonging to the Compositae family. It is prepared in the form of a tea (infusion) but must not be treated with hot water if the therapeutic virtue of this herb is to be retained. It is prepared by placing four tablespoons of Matricaria (German Chamomile flowers) in a large vessel, adding a gallon of luke-warm water, covering the vessel with a lid and letting it simmer over a low flame for fifteen minutes. Then the preparation is strained through gauze, and the liquid is ready for use as a wet dressing.

Cortico-steroids are also helpful in poi on ivy dermatitis. Used for two or three days at the height of the inflammatory state of the dermatitis, they minimize the itching. With cortico steroids the local discomfort largely disappears. I prefer methyl-prednisolone in doses of 16 to 40 milligrams for older children, 8 to 12 milligrams for younger children, best given in four divided doses, preferably after meals and at bedtime.

Occasionally, mild sedation is indicated together with the cortico-steroid therapy. Acetylsalicylic acid may be prescribed for this purpose in doses of 65 milligrams for each year of the child's age (maximum dosage 0.6 Gram) given several times daily.

VERRUCAE

THE three types of warts most often seen in children are (1) the common wart (verruca vulgaris, (2) the juvenile flat wart (ver-

ruca planae juvenilis), and (3) the plantar wart (verruca plantaris).

The *common wart* (single or multiple) is usually distributed over the fingers and upon the dorsa of the hands. It is a circumscribed elevation, sharply rounded or irregularly projecting, pinhead to pea-size papule, and gray, grayish-black or yellowish in color. One of the distinguishing features which differentiate it from molluscum contagiosum is its roughened surface, *i.e.*, exhibiting small, villous, roughened edges.

Juvenile flat warts appear as only slightly elevated lesions, sharply circumscribed, round or polygonal, or a normal skin color or only slightly yellowish-gray or brown. They vary from millet seed-sized to pea-size and are found on the cheeks, forehead, chin, and the temporal areas, and on the dorsa of the hands. Linear formations are not uncommon, particularly following scratch marks (Koebner phenomenon).

Any wart occurring on the plantar surface of the foot is naturally called a *plantar* wart. Because of the constant pressure in walking, this type of wart grows inward instead of outward as does the common wart. Plantar warts are tender, especially when pressure is exerted upon them laterally. Usually pea-sized, they are covered by hyperkeratotic material, which when pared away, discloses numerous small black specks.

Warts should be destroyed. One method is the use of escharotics. The escharotic may be 10 to 40 per cent of salicylic acid dissolved in a flexible collodion and applied. Or it may be full-strength mono-chlor-dichlor or trichlor acetic acid. Dry ice (carbon dioxide snow) applied for a period from thirty to sixty seconds is another option. Lunar caustic (fused silver nitrate stick), also may serve. Liquid nitrogen may be applied by means of a cotton tipped applicator. Also available are surgical excision or a galvanocautery.

Juvenile flat warts, when they are few in number, may be treated by the cautious application of trichloracetic acid; but care must be taken to prevent the acid from injuring the adjoining normal skin. When the warts are present in large number, sulfurated lime solution (Vleminckx' lotion), in the proportion of one to two tablespoons to one pint of hot water, may serve as a compress applied to the lesions for a period of ten to fifteen minutes several times daily. Psychotherapy seems of questionable value.

In children the excess callous tissue of the plantar wart should be pared away before a 40 per cent salicylic acid is applied which should then remain in place for several days. This application should macerate the skin sufficiently to allow the wart to be pulled out by a scalpel. If it fails then perhaps electrodesiccation and curettage under procaine anesthesia may be in order. Recently considerable interest has been shown in the removal of plantar warts by the injection of vitamin A (Keramin®) directly into the wart.

MOLLUSCUM CONTAGIOSUM

THIS is the condition that the laity call "seed warts." The lesions consist of minute, elevated papules, acuminate, pin-head to large pea-size, or again, slightly flattened and ovoid. They will be slightly reddish, yellowish or whitish. When the lesions are very young, they may be difficult to diagnose. Later the typical globoid, firm, of a waxy appearance, semi-translucent with its central depression or "umbilication" through which tiny opening a cheese-like curd may be expressed (mollusk bodies), renders diagnosis simple. These lesions may be distributed anywhere on the body although they are commonly seen on the face, the upper eyelids, the neck, the external genitalis and on the trunk.

The indications in management are to remove the lesions with as little damage to the skin as is possible and to prevent recurrence. First, the affected child should be isolated from his playmates to prevent the spread of the infection to others. It is in respect to this infection that destructive methods are often used to get rid of the lesions. One effective method

opens the individual lesions and expresses their contents, which are caught up on gauze or absorbent cotton and then disposed of. The base of each lesion is then painted with 2 per cent tincture of iodine or touched up with lunar caustic stick (fused silver nitrate); or, instead, trichloracetic acid may be used. An apprehensive child may require an ethyl chloride spray before the escharotic is applied. For widespread lesions wet dressings of sulfurated lime solution (Vleminckx' lotion) are worth a trial. The solution should be used as hot as the skin can bear it, for fifteen or twenty minutes at a time, several times daily. In a recent report[1] one investigator used 0.9 per cent of cantharidin dissolved in equal parts of acetone and flexible collodion, applied directly to the lesions with good effect.

SEBORRHEIC DERMATITIS

THERE are two types of seborrheic dermatitis, the generalized and the localized. The type localized upon the scalp is known as "cradle cap" or "milk crust." Forming on the glabrous skin, these lesions may begin as a papular folliculitis which will enlarge to form plaques or circular or oval-shaped lesions of a yellowish or reddish-yellow color, scaly and greasy to the touch. Or again, there may be dry scales which under certain conditions present exudation and crusts. In seborrheic capitis, too, one finds yellowish or yellowish-red, scaly or crusted patches that are greasy to the touch.

The areas of predilection include the scalp, the root and sides of the nose, the nasal fold, the postauricular areas, the circumoral area, the axillae, the sternum and the spinal column, the umbilicus, the groins, the genitals and the perianal region.

Indications in management are to remove the scales and to prevent their recurrence. The first phase of treatment is carried out by means of anti-seborrheic remedies; however, it is not always possible to prevent recurrence.

Useful anti-seborrheic remedies include precipitated sulfur 3 to 5 per cent; salicylic acid 3 to 5 per cent; the tars (coal tars, the wood tars, and shale tars) beginning with 1 per cent and gradually increasing the concentration to 5 per cent strength; Vioform† 1 to 3 per cent. These may be ordered in an olive oil vehicle or as creams or ointments. The following prescription provides an example of an anti-seborrheic oil:

℞

Salicylic acid (2 to 5 per cent)	2.0 to 5.0 Gram
Castor oil	
Olive oil aa q.s. ad	100 c. c.
Misce et fiat	
Signa: Apply to scalp or body t.i.d.	

LICHEN URTICATUS

THE primary lesion of lichen urticatus is a small pruritic papule which usually appears in crops or as discrete lesions, usually on the extensor surfaces of the arms or legs, the face and neck. The trunk generally remains free of lesions. In the acute phase the lesion is usually surrounded by an urticarial wheal; whence the term lichen urticatus (*urticaria papulosa*). Sometimes the papule is surrounded by a small area of redness and may even be capped by a vesicle. Pruritus always is part of the symptomatology. Numerous scratch marks and impetigo contagiosa follow as complications. The condition is liable to recur.

The most important indication in management is to break up the "itch cycle." When this is accomplished, involution of the lesions follow. Exogenous factors, such as bites from fleas and insects, are overcome with insecticidal and ovacidal remedies. Allergenic foods should be cooked or stewed. A 5 per cent DDT in talc is an excellent insecticide and may be used as a dusting powder on house-

†Vioform® is the Ciba proprietary tradename for their brand of chlor-iodo-hydroxyquinoline.

1. Epstein, W. L. and Kligman, A. M.: A.M.A. Arch. Dermat., 77:508 (May 1958); Epstein, J. H. and Epstein, W. L.: Calif Med., 93:11 (July 1960); and Funt, T. R.: A.M.A. Arch Dermat., 83:504 (March 1961).

2. Charpy, J. and Grapin, A.: Lyon med. 175 (Feb. 24) 1946; ibid. 175:129 (March 3) 1946.

hold pets. Charpy [2] has reported good results, too, from a 10 per cent solution of Metrazol‡ which a child over two years of age may receive, in milk or fruit juice, 10 to 20 drops, three times daily, for five days.

GRANULOMA ANNULARE

GRANULOMA ANNULARE is also known as "ringed eruption" because the lesions are ringed-shaped or round. Frequently it is mistaken for ringworm of the skin (*tinea circinata*). Two types of granuloma annulare are seen clinically; the classical discoid type (the more common) and the disseminated type. The discoid type begins as a single, infiltrated papule, usually pea-sized and extending itself peripherally until it reaches the size of a coin, perhaps the size of a quarter or even a half dollar. A solid border of nodules, perhaps slightly elevated or a firm to hard or sometimes of a slightly doughy consistency, forms the margin of the lesion. The central portion is usually depressed while the covering skin is either normal or atrophic and of a slightly pinkish color.

The differentiation of granuloma annulare from *tinea circinata* should not, however, be difficult. Findings in favor of diagnosis of ringworm of the glabrous skin (*tinea circinata*) are that the lesions are macular, not papular. This lesion is characterized by a raised peripheral border consisting of vesicles (not nodules). The center of the lesion is not depressed. Also, one can usually demonstrate a ring within a ring. The lesion is slightly erythematous and scaly. If it appears in an area of lanugo hairs, the hairs will show a green fluorescence under the Wood filter (microsporum lanosum or audouini). Or, if the scales are placed on a glass slide and treated with 10 per cent potassium hydroxide, mycelia may be demonstrated and a culture will be positive on Sabouraud's medium. Number is significant, since there are seldom more than half a dozen of ringworm lesions to be seen on the glabrous skin.

Management consists either in destroying the lesions or by using remedial agents parenterally or by mouth. It is interesting how often one sees a spontaneous involution following upon the simple taking of a biopsy. Methods of destroying the lesions include the use of dry ice (carbon dioxide snow) applied for a period of from 10 to 40 seconds at weekly or bi-weekly intervals, and by the spraying of the lesions with ethyl chloride and their incising afterward by a series of four or six spoke-like strokes made directly over each lesion by a Bard-Parker pointed blade.

Calciferol®* has been used by mouth with apparently good results in many cases. Another method consists of the injection of bismuth subsalicylate in oil intramuscularly.

PITYRIASIS ROSEA

PITYRIASIS ROSEA involves macular, papular and vesicular lesions. Usually one sees either the macular or papular type or a combination of these lesions—maculo-papular. The herald patch (sentinel) lesion ushers in the dermatosis, which has a seasonal aspect, being definitely more common in the fall and in the spring. The herald patch usually precedes the generalized eruption by a week to ten days and may be found anywhere on the skin, even on the scalp. There may be one or more herald lesions which are often mistaken for ringworm of the skin.

The generalized eruption consists of circinate or oval-shaped, macular lesions of a pinkish-salmon color, with a cigarette-like, crinkled-paper scale. After a short time these scales loosen and break in the center, although the edges remain attached to the periphery of the lesion. Upon this one point alone a diagnosis of pityriasis rosea can be made inasmuch as there is no other lesion that resembles it in all dermatology. The long axis of the macule follows the line of cleavage of the ribs on the chest. When full-blown, the rash resembles in

‡Metrazol® is the Knoll tradename for their brand of penta-ethylene-tetrazol.

*Calciferol® is the proprietary tradename for the Kremers-Urban brand of a vitamin D2 preparation.

outline an inverted Christmas tree. The papular type may resemble an "id" reaction. The areas of distribution include the trunk, face, neck, shoulders, arms, forearms, axillae, buttocks and the thighs. The lesions involute after 6 to 10 weeks.

The indications in management include the relief of itching and antiphlogistic topical remedies. Soap and water should be avoided; instead colloid baths should be used. Suberythema doses of ultraviolet light from an air-cooled mercury vapor lamp are often helpful and the use of typhoid-paratyphoid vaccine (0.5 cubic centimeter given every five days, subcutaneously, for three doses) is useful in shortening the disease (foreign protein therapy).

SUMMARY

BASIC understanding of the histopathology of some of the common dermatoses is of fundamental importance for management. Many of the dermatoses are worsened because of the misapplication of the topical remedy at a particular stage of the disease. Remedies used without a precise knowledge of what they can accomplish and without specific indications are like navigating at sea without a pilot. The keys to successful dermatologic therapeutics are: first, correct diagnosis and second, conservatism and simplicity in the use of remedial agents. With these guiding principles, the objective desired, the return of a sick skin to its normal state, can be achieved in the shortest possible time.

1737 Chestnut Street

Are Psychoses of Chemical Origin?

Sometimes a mental patient is helped by medication. The chemist's contribution to the therapeutic onslaught on mental illness is a large one indeed. There are drugs to calm manic excitement, to alleviate severe depression, to control convulsions, and so on.

But chemistry has contributed not only in the matter of treatment but also as regards the genesis of mental illness. One outstanding example is the discovery that a rare but severe form of mental defect, phenylketonuria, is caused by a failure of body chemistry. This abnormality has now yielded its secret, can be detected early, and can even be controlled through diet.

In other fields of research also, the chemical approach is being employed and may yield valuable results. Emotional disaster can upset the body chemistry. This is widely recognized today, and can be clearly seen, for example, in diabetic patients who may be precipitated into a coma by an emotional upset just as easily as by an infection. Much depends on the individual's receptivity to frightening situations. An increase of epinephrin in the blood is one of the normal responses to fright. The effect of this substance on the electrical activity of the brain and the nervous system may well account for the tendency in anxious people to misinterpret external experience. The frightened sentry, crouching alone in his foxhole, tends to mistake a tree for an approaching enemy, a creaking bough for the sound of a crawling man, perhaps simply because of an excess of epinephrin. The next stage towards a truly pathological condition may come about by exhaustion, caused for example by lack of sleep, with actual hallucinations and disorders of thinking. This has been studied in volunteers who have taken part in sleep-deprivation experiments.

Much research on the biochemistry involved in such changes needs still to be done, but disturbances of contact with reality in normal persons can also be brought about by a number of drugs, some of which have long been known. Some others of recent discovery may in appropriate doses produce various forms of mental disorder in healthy persons, undoubtedly by acting on the biochemical equilibrium of the brain. Will it be possible to use these "model psychoses" in order to discover the biochemical disturbances that underlie the disorders? If positive results could be obtained, we might be able to prepare substances that would counteract them. The search is on.

World Mental Health, August 1961

Jacques B. Wallach, M.D
Cranford

Komei Nakao, M.D.
Bronx, N. Y.

Hamartoma of the Spleen*

Hamartoma of the spleen is rarely diagnosed: in fact, it is rarely even thought of. Here is a brief account listing three cases.

Hamartoma of the spleen has been reported infrequently and many of the cases are inadequately described. Hamartomata occur more often than reported, but are confused with other lesions such as hemangioma and metastatic carcinoma. A small hamartoma is easily overlooked. Lack of recognition and confusion are reflected by the myriad of terms which have been used: splenoma, spleen within a spleen, splenadenoma, fibrosplenoma, nodular hyperplasia and so on. These are presently considered hamartomata by most observers.

The morphologic appearance of hamartoma is sufficiently characteristic to permit recognition. The whole spleen may be normal in size, atrophic, or considerably enlarged and may exceed 2000 Grams in weight. Hamartomas are located within the splenic parenchyma but may produce external distortion of the spleen; only one instance showed surface involvement.[3]

Grossly these lesions are spherical and usually solitary; only three spleens had multiple nodules. Hamartomas vary in size from several millimeters to 11 centimeters. They are well defined and well demarcated but not truly encapsulated. They are often more fibrous and resilient and more gray or tan as compared to the adjacent splenic parenchyma, and contain less blood than the surrounding spleen.

Calcification is rare. Microscopically, a capsule is lacking although compressed trabeculae at the border of the hamartoma may simulate a capsule. Within the nodule, trabeculae and follicles are usually absent, indistinct, or distorted. Either red or white pulp may predominate. The pulp, trabeculae, and follicles are irregularly distributed and lack the interrelationship characteristic of normal splenic architecture. This permits ease of low power differentiation from the adjacent parenchyma. The contrast is more striking if prominent fibrosis is present. An outline of previously reported cases is summarized in the Table. Similar lesions[1] have been described in animals.[1,6]

Hamartoma of the spleen occurs with equal frequency in men and women. It has been reported in the young as well as the elderly. It

*From the Department of Pathology, Albert Einstein College of Medicine, Bronx Municipal Hospital Center, New York 61, New York.

1. Mordasini, E.: Uber Splenoma (Hamartoma) der Milz, Virchows Arch. f. path. Anat. 298:594 (1936-37).

2. Sweet, H. H. and Warren, S.: New England J. Med. 226:757 (1942).

3 Kirkland, W. G. and McDonald, J. R.: Arch. Path. 45:371 (1948).

4. Coe, J. I. and Von Drashek, S. C.: Hamartoma of the Spleen. Am. J. Path. 28:663 (1952).

5. Henke, F., and Lubarsch, O.: *Handbuch der speziellen pathologischen Anatomie und Histologie,* Julius Springer, Berlin, 1927, Page 695.

6. Monari, D.: Arch. ital. di anat. e istol. pat. 3:33 (1932). (cited by Sweet and Warren, at reference 2 above).

is most frequent in adults over the age of 50. Hamartomas are benign. There are no associated hematologic findings. Five patients had clinical findings such as an enlarged palpable spleen. Most of the patients were asymptomatic and the lesions were incidental postmortem findings. It is important to avoid mistaking these lesions for lymphoma or metastatic neoplasm at surgical exploration lest improper therapy be used or an incorrect prognosis be given to the patient and his family. The correct diagnosis is usually not made clinically.

CASE ONE

A 3½ year-old boy was admitted to the Bronx Municipal Hospital Center because of recurrent swelling of the left parotid region. He had been previously hospitalized on two occasions because of recurrent episodes of painless left parotid swelling associated with low grade fever and anorexia lasting 3 to 6 days. The liver was palpable 3 centimeters below the right costal margin. A nontender spleen was palpable 4.5 centimeters below the left costal margin in the anterior axillary line. The splenic notch was not felt. X-ray showed a mass in the left upper quadrant of the abdomen independent of the kidney and gastro-intestinal tract. A splenectomy was done and postoperative recovery was without incident.

The spleen measured 12.7 by 7 by 4.6 centimeters and weighed 150 Grams. External surface was purple red and smooth. On section there was an elevated, bulging, well demarcated, resilient, firm nodule measuring 5.4 centimeters in diameter located in the lower pole. Its cut surface was coarsely lobulated and finely divided by depressed, white, fibrotic strands. (Figure 1) The rest of the specimen revealed distinct follicles without gross abnormalities. Microscopically, the lesion was principally composed of red pulp and contained no trabeculae or follicles. Compression of the adjacent parenchyma simulated a capsule.

CASE TWO

A 74-year old woman was admitted to the Bronx Municipal Hospital Center because of cough productive of blood-tinged sputum for one week. She had been treated for hypertension, congestive heart failure and auricular fibrillation for 2½ years. On the 17th hospital day she died suddenly and unexpectedly. The spleen had never been palpable and no hematologic abnormalities were noted.

At autopsy, pulmonary emboli with superimposed thrombosis occluded both pulmonary arteries; numerous small organizing emboli were also found. There were areas of pulmonary infarction in both lower lobes. The right leg was edematous and enlarged with prominent superficial veins. The spleen weighed 80 Grams. The capsule was thin and transparent. The cut section was firm with a normal trabecular pattern but contained a round, firm, gray white nodule, 12 millimeters in diameter. (Figure 2) Microscopically, this nodule was composed of red pulp and trabeculae; follicles and a capsule were lacking. There was some compression of the adjacent parenchyma.



Figure 1. Hemisected spleen of Case 1, showing well defined nodule enlarging the lower portion of the spleen.

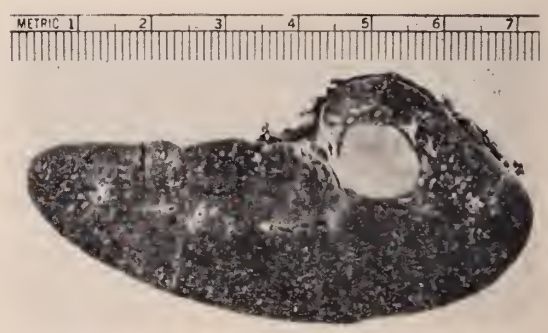


Figure 2. Gross photograph of cut section of spleen illustrating the well defined hamartoma (Case 2).

CASE THREE

A 72 year-old woman was admitted in coma to the Bronx Municipal Hospital Center. A known diabetic for 15 years, she had been controlled with insulin. She had been treated with digitalis for heart failure for many years and had been relatively asymptomatic until the morning of admission when she was found lying on the floor several minutes after appearing normal. On admission blood pressure was 260/110. Her pulse was 120 with auricular fibrillation and a left hemiparesis. There was a grade 2 apical systolic murmur. The liver was felt 2 finger breadths below the right costal margin; the spleen was not palpable. The right carotid pulsation was slightly less than on the left. The

patient developed hyperpyrexia and died soon after admission. At autopsy the significant findings were hemorrhagic infarcts of the right parietal lobe of the brain, nephrosclerosis and congestion of the viscera. Grossly, no lesions were noted in the spleen; microscopically there was a spherical area 15 millimeters in diameter located three millimeters below the splenic capsule. (Figure 3) The nodule was composed of red pulp with no capsule or follicles. A few thin and irregular trabeculae were present. There was some compression of the adjacent parenchyma.

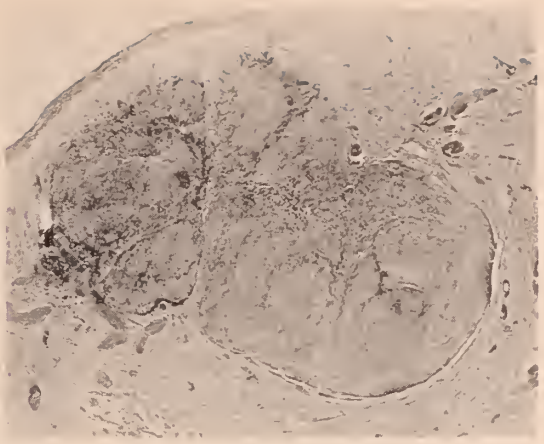


Figure 3. Microphotograph illustrating ease of low power differentiation from normal splenic parenchyma. Note absence of capsule, trabeculae and lymphoid follicles in hamartoma. (Periodic acid-Schiff 15X) (Case 3).

SUMMARY

PREVIOUSLY reported cases of hamartoma of the spleen are tabulated and three new cases are reported. The benign nature and usual asymptomatic course make the lesion an incidental finding at autopsy. The morphologic features are the solitary occurrence of a well defined nodule lacking a capsule, a variable size, and an aberration in the arrangement of the splenic histology. The importance of correct diagnosis and its ready recognition are noted.

TABLE 1.

Author	Age & Sex	Clinical and Autopsy Data	Spleen
Rokitansky and Anesinger [1]	*	*	Bean-sized, deep spherical tumor.
Virchow and Orth [1]	*	*	Lighter colored, poorly delineated raised nodule.
Weichselbaum[1]	1) Aged female	*	Lighter colored, bean-sized, soft nodule.
	2) Young soldier	*	
	3) Young soldier	*	
Cesaris-Demel [1]	76 female	Myocarditis, congestive heart failure	Subcapsular, 8 cm. nodule with fibrous central core, distinct venous sinuses, few lymphoid follicles, calcium and hemosiderin deposits.
Stuck [1]	72 male	Chronic splenic tumor. Death following prostatectomy	Deep 2 cm. light-colored nodule, distinct but interrupted capsule, distinct trabeculae, pulp with thickened reticulum, narrow venous sinuses, no follicles.
Pistocchi [1]	*	*	Distinct fibrous capsule, nodule with pulp, trabeculae, and follicles.
Vigi [1]	53 male	Pachymeningitis hemorrhagic interna	Deep 5 cm. nodule, red, firm, thick trabeculae, wide venous sinuses, no follicles, no capsule.
Kubig [1]	*	*	Normal size and consistency of the spleen. Near hilus wide-stalked, firm, dark red, cherry-sized nodule. Poor trabeculae, remnant of fibrotic follicles, fibrotic pulp with hemorrhage.

Schridde [1]	*	*	Cherry-sized, whitish, delineated nodule. Mostly lymphoid tissue with less pulp.
Schinz [1]	18 female	Meningitis. Acute splenic tumor	In depth, *many* well delineated, bean to nut-sized nodules, spongy and bright red; mostly pulp elements with a fine reticulum, few small follicles and few peripheral trabeculae. No capsule.
Orlandi [1]			
Case No. 1	76 female	Broncho-pneumonia	Atrophy of spleen. In upper pole a round, firm, red, 3.5 cm. nodule. Pulp type, with wide blood-filled sinuses, many trabeculae, no typical follicles but occasional lymphocytic collection, no capsule.
Case No. 2	36 male	Arteriosclerosis with rupture of aorta. Chronic splenic tumor	Firm, 3 cm. gray nodule, poorly demarcated, bloodless pulp with a fine reticulum, wide venous sinuses, few small follicles, no trabeculae or capsule.
Businco [1]	58 male	Edema of glottis. Gas embolism. Malaria	In upper pole, round, firm, 6 cm. nodule, central partially calcified fibrous core with radiating trabeculae and pulp tissue in between, rare follicles in periphery and lymphocyte collections in other parts of nodule.
Lubarsch [1]	5 female	*	A bulging whitish, cherry-sized nodule composed of pulp, reticulum, and bloodless sinuses; no follicles, no trabeculae, no capsule.
Adami, Nichols, Barantschik, Lanceraux [1]	*	*	*
Mordasini [1]			
Case No. 1	23 male	Pulmonary tuberculosis	Normal sized spleen. At anterior pole of spleen is encapsulated, stalked 11x8x7 cm. thin, dark red, congested, pulp type, blood lakes, no lymph follicles.
Case No. 2	84 male	Broncho-pneumonia	Inferior surface of spleen, 11 cm. firm, dark red; pulp type, almost normal follicles, no capsule.
Case No. 3	55 female	Congestive heart failure	5 cm. dark red, subcapsular, soft nodule, poor delineation, few follicles, no capsule.
Case No. 4	25 male	Thymoma with metastases in lung, pleura and lymph nodes.	5 mm. dark red nodule. No follicles, no capsule.
Case No. 5	49 male	Lung cancer with metastases.	Normal sized spleen, 8 mm. gray delineated nodule, less follicles than in normal part. Mixed pulp and trabeculae type.
Case No. 6	63 female	Gangrenous appendicitis with perforation, peritonitis with acute splenitis.	Many nodules up to 1 cm. poor delineation, no follicles.
Sweet & Warren [2]	59 female	8 months of abdominal enlargement.	1120 gms., 23x17x7 (grapefruit-size). Lower 2/3 bulbous and almost cystic in consistency. Irregular increase in fibrous stroma replacing some of the pulp. Ill-defined corpuscles. No capsule.
Fischer (in Sweet & Warren) [2]	42 male	*	2100 gms.

Kirkland & McDonald [3]			
Case No. 1	38 female	Surgical removal of incidental palpable spleen	500 gms., 7 cm. (occupied most of the spleen). Extensive infarct, no mention of follicles or trabeculae.
Case No. 2	72 female	*	850 gms., 10 cm. in greatest dimension, 8 cm. nodule.
Case No. 3	41 female	6 years of dull, heavy sensation in LUQ. Death 7 months later —No cause or autopsy given.	1100 gms., many elevated surface nodules 0.1-2 cm. Normal spleen.
Coe & von Drashek [4]			
Case No. 1	60 female	Traumatic ruptured spleen.	300 gms. tumor, 6 cm. spherical, sharply demarcated, soft gray white. Line of rupture at border. Not encapsulated, no follicles or trabeculae, many sinusoids.
Case No. 2	68 male	Congestive heart failure. Incidental autopsy findings.	"Enlarged." Tumor spherical, sharply circumscribed in center near hilus. Similar to red pulp, no trabeculae or follicles, arteries infrequent and poorly developed.
Case No. 3	79 male	Congestive heart failure. Incidental autopsy finding.	600 gms., 9 mm. Spherical, sharply circumscribed, 2 cm. beneath capsule in midportion, firm, slightly elevated, light pink. Fibrous tissue containing many irregular sinusoids. No capsule, follicles or trabeculae: few small arteries.
Case No. 4	39 male	Diffuse polyposis of rectum. Incidental autopsy findings.	200 gms., 2 cm. light gray, sharply circumscribed. Follicles and fibrotic trabeculae small and widely scattered. Sinusoids normal.
Wallach & Nakao			
Case No. 1	3½ male	Incidental clinical findings of abdominal mass.	150 gms., 12.7x7x4.6 cm. Distinct, not encapsulated. No trabeculae or follicles, marked fibrous bands.
Case No. 2	74 female	Incidental autopsy finding.	80 gms., 1.2 cm. spherical nodule. Red pulp and trabeculae. No capsule or follicles.
Case No. 3	72 female	Incidental autopsy finding microscopically.	Spherical area 1.5 cm. Distinct, not encapsulated. Red pulp and trabeculae. No capsule or follicles.

*Information not given

1130 Raritan Road

Thanks are extended to Mr. Milton Kurtz for the photography, both gross and microphotographic.

Funerals Are Expensive

"Nobody several years ago survived the series of illnesses that I have had. If someone tells me that the medicines I carry are expensive, I must laugh, particularly when I read circulars advertising graves. I would rather pay for a medicine than a grave any day."

—George E. Sokolsky, columnist, King Features Syndicate.

R. B. Robertson, M.D.

W. L. Wood, M.D.

W. A. Jamison, M.D.

Red Bank

Micro-Surgery of the Ear

In a sense, micro-surgery has meant a dramatic breakthrough in operative otology. The authors here discuss technics, pitfalls and results.

Otology has been drastically changed by recent advances in micro-surgery aimed at correction of the deafness resulting from otosclerosis, and reconstruction of the middle ear and tympanic membrane damaged by old infection. The previously destructive mastoid surgery for eradication of infection has given way to tympanoplastic procedures. Hearing has improved. Middle ear and adjacent cholesteatomas have been removed. Middle ears have been cosmetically sealed with grafts, free and pedicle, of such things as vein, skin and cornea. It is our purpose to relate some of our experiences with this type of surgery done in a community hospital.

OTOSCLEROSIS

Hearing has been markedly improved in otosclerosis by methods of Shea,[1] House [2] and others. Of these, Shea's method [1] of vein graft and polyethylene prosthesis, after total stapedectomy, has enjoyed the greatest popularity.

Before the operating microscope, a loupe was used in the earlier cases after the publication by Rosen, of hearing improvement by inadvertent stapes mobilization, in an otosclerotic patient. This provided the stimulus for tremendous effort in this area. It became apparent, to us as well as others, that simple mobilization with modification such as anterior crurotomy, was *not* the answer. Rapid fixation became the rule rather than the exception. The reports following the use of the vein graft and polyethylene prosthesis technics after stapedectomy encouraged us to turn to this method. Results have been, for the most part, gratifying. For this reason, we have not tried the other technics advocated such as the vein plug with wire prosthesis (Cos[3]) or Gelfoam®,† or fat as a substitute for the vein graft.

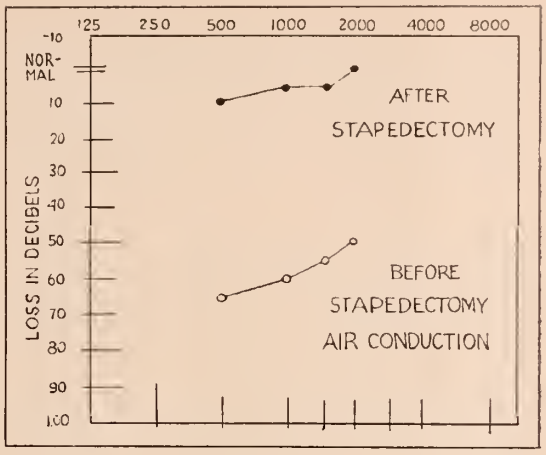
We have accepted for surgery, in some instances, patients with poor cochlear reserve. Often there has been a surprising improvement in bone conduction. The poorer ear has always been done first. To date, the second ear has not been operated sooner than six months after the first. In almost no instance have we used prophylactic antibiotics or sulfonamides. This was at the suggestion of our committee on antibiotics. There have been no more infections than other groups have presented. In one group of general surgical infections, it was found that when antibiotics were used prophylactically, the incidence of staphylococcus infection was actually *higher* than when no antibiotic was used before and after surgery. We have, in some instances,

†Gelfoam® is the Upjohn tradename for their brand of absorbable sponge.

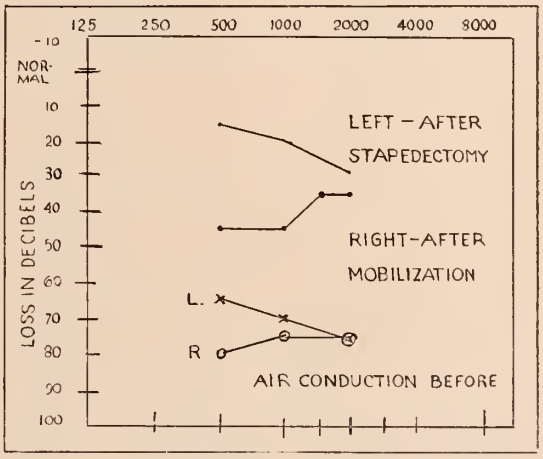
spread our vein graft out thinly on the back of the rubber-gloved hand and pres ed a thin piece of Gelfoam®† onto it. In this way it has acted as a scaffold and has kept the vein from retracting when placed over a tympanic membrane perforation or over the oval window.

The surgical technic has been described thoroughly elsewhere,[4] and will not be discussed in detail here. Principles and method of fenestration outlined by Shea,[1] have been clo ely adhered to. The cases cited below are typical of results obtainable with this technic.

Audiogram number 1 illustrates the hearing improvement with Shea's operation. The circles indicate pre-operative air conduction in the right ear, dots represent postoperative air conduction in the right ear. Audiogram number 2 provides a comparison of routine mobilization with the Shea procedure. A stapes mobilization was performed on the right ear with the anterior crurotomy technic. The symbols are the same as in audiogram number 1. The hearing level is of one year, postoperatively. Although definite improvement is present, the gap is not closed and the patient has not reached the 30 decibel level. (Moderate nerve loss, is of course, present here). In contrast, the result of stapedectomy with vein graft and polyethylene prosthe is is shown by the dash line. This ear was operated on fourteen months after the right ear. Closure of the air bone gap and improvement of hearing to the level of 30 decibels or better in the speech frequencies is present, despite nerve loss. For simplification, audiograms show only the speech frequencies.



Audiogram 1.



Audiogram 2.

TYMPANOPLASTY

WHAT procedures have been designed to repair the damage resulting from infection? Attempts have been made in the past to obtain these goals, notably by the modified radical mastoid, entering *via* the endaural route. This required that the ossicular chain and tympanic membrane be intact; or that an intact tympanic membrane could be brought into contact with a functioning stapes to produce a columella effect. These limitations markedly limited the number of patients who could be helped by this procedure. It was theorized that the tympanic membrane could be reconstructed, and that means could be devised to provide continuity between an intact drum and a mobile stapedial foot-plate. If, at the same time, a ventilated middle ear were obtained, function would be restored. This was true, but until the advent of the operating micro cope, it was not only extremely difficult accurately to assess the amount of disease, but proper visualization of the operative field was precluded.

As soon as the operating microscope became available, tympanoplastic procedures became a reality. Wullstein[5] and Zollner,[6] in Germany and other workers in this country, notably Schuknecht,[7] House,[8] Juers[9] and Shambaugh,[10]

have contributed to the development of this field, which is still in a state of flux.

Wullstein [5] has classified reconstructive procedures for defects of the middle ear. His outline gives an idea of what type of problem can be overcome.

Type I—A perforation of the tympanic membrane is closed. (Myringoplasty)

Type II—The superior portion of the middle ear is entered and disease in this area and the mastoid antrum is exenterated. The tympanic membrane is also repaired, if necessary.

Type III—The ossicular chain has been destroyed by disease and reconstructed drum is brought into contact with the stapes, if intact; if not, a prosthesis is interposed.

Type IV—The drum is brought into contact with the promontory. Again, the ossicular chain is absent.

Type V—In this procedure (rarely done) the drum is repaired and a new route for sound transmission is produced by fenestration of the horizontal semicircular canal.

This outline indicates the many situations which may confront the otologist. However, Rambo's classification [11] will be used here. In this system, we recognize a first type in which only closure of a tympanic membrane perforation is necessary; and a second group in which more extensive reconstruction is required. Many different tissues have been used, as have many prosthetic materials. We have, however, limited ourselves to skin, and more recently vein, with polyethylene tubing when prosthesis was required.

Closure of the tympanic membrane has, in almost every instance, given good results. Occasionally a marginal dehiscence has occurred which has closed with office treatment. We have found vein grafts to be extremely satisfactory in all but the largest perforations. The results and problems we have encountered in other types will now be discussed.

PITFALLS AND COMPLICATIONS

1. Long standing history of chronic scarred tympanic membrane with occasional suppuration. The scar tissue was removed from the middle ear as well as the thin membrane which had replaced the ear drum. A number 50 plastic strut was placed over the remaining portion of the posterior crus and made to contact a vein graft which was used to replace the drum. A piece of tubing was allowed to extrude from the eustachian tube well into the middle ear. In five weeks hearing improved from 55 to 20 decibels, at 1000 cycles and 60 to 20 decibels at 2000 cycles. This was one of the few good results obtained by this and similar procedures. When healing was complete, a small superior perforation remained.

2. In this patient there was a history of acute vertigo in 1955 when a cholesteatoma was noted through a superior-posterior marginal perforation. This was removed by irrigating with ether. She had two episodes of discharge following upper respiratory infection until late in 1960. At that time a vein graft was applied over the perforation, which occupied about one-fifth of the total eardrum. The closure was excellent, except for a small anterior dehiscense.

3. There had been a history of draining left ear from an anterior marginal perforation. This had taken place for some months and after cholesteatomatous material was irrigated, she remained dry. Eight months later, a vein graft was used to close the perforation. Two months later, a marginal perforation appeared superiorly and posteriorly to the original. Cholesteatoma appeared and when irrigated with ether, has remained dry to date. The anterior perforation has remained closed.

4. This patient had scarred bilateral intact drums resulting from an old suppurative process as a child. Hearing loss averaged about 30 decibels. Left tympanoplasty was done, and the middle ear found to be solid with scar tissue. This was dissected free with considerable effort. The stapes and incus were for the most part absent, and a polyethylene tube was placed between the foot-plate and the tympanic membrane. Gelfoam®† was placed in the middle ear to maintain its position.

The improvement in hearing was slight. The most interesting part of this operation occurred when dissecting scar tissue in the region of the facial canal. The patient felt a twinge in his left jaw. When his face was observed, he had what appeared to be a com-

plete left facial paralysis of peripheral type. He was kept on steroids for three weeks. At the end of six weeks (postoperatively) the function had almost completely returned; there remaining a slight lag at the corner of the mouth.

All in all, the results from closure of perforations with vein grafts have been satisfying. Where the ossicular chain has been intact, the hearing has improved.

In an effort to improve hearing where parts of the small bones have been shown to be absent by substituting polyethylene tubing results have not proved satisfactory.

STAPEDECTOMY

1. Stapedectomy was done using a vein graft to close the oval window. Number 50 tubing was inserted. Results on the table were excellent. On the second postoperative day, the patient was beseiged by a fit of sneezing. This was followed by subjective drop in hearing and a rather marked vertigo which had not before been noted. The vertigo got worse, to a point of rather marked incapacity. Seven days after the initial surgery, he was explored and the vein and tubing found to have been forced well into the vestibule. Evidently this had been caused by the sneezing which had increased pressure within the middle ear. The vein was replaced, as was the tubing, and recovery was uneventful. Vertigo subsided rapidly. His hearing, however, never did improve to the immediate postoperative level.

2. In this woman, a mobilization was done in August 1958, with excellent closure of the air-bone gap. Within six months her hearing had diminished to near its original level. In August 1959, the ear was re-operated and because of minimal anterior disease, a conservative technic was utilized. The anterior crus was divided and the foot-plate stippled through the middle. Results showed some improvement in hearing, but not to the level originally achieved by mobilization. It should be added here that this patient had a small central perforation from an old otitis media which was closed at the time of the first operation. Skin was used. The perforation remained closed for three months when suddenly it appeared again.

At a third operation late in 1960, the perforation closed again. This time a vein graft was used. At the same time a stapedectomy, following the technic of Shea[1] was carried out. She heard well on the table, but about a week later became dizzy and the ear suppurated. From all evidence this was confined to the external canal, for it dried up immediately upon one application of topical antibiotics. This patient gradually lost all perceptive hearing on the operated side; however, the tympanic membrane perforation has remained successfully closed for six weeks.

We have noted that in many instances perilymph has been aspirated from the vestibule during the operative procedure. In other instances blood has seeped in, yet the effect has not been detrimental to some of our best results. In many instances, promontories have had to be burred down to get at the foot-plate. Some foot-plates have been so thickened that to first look at them was discouraging. Pieces of foot-plate have been lost in the vestibule yet successfully removed with the suction; the results have gone on to be excellent in spite of the labyrinthine disturbance on the table.

Results on the whole were good with our mobilizations, when mobilization occurred. They, however, did not last. With stapedectomies, after the method of Shea, our results in closing the bone gap have been uniformly good, and we have found them lasting.

SUMMARY

We have used fenestration of the oval window with a vein graft and prosthesis according to Shea's technic. Although difficulties are encountered (and are here discussed) results, on the whole, are good. Also encouraging has been our experience with myringoplasty.

76 Branch Avenue

A list of citations will be found in the authors' reprints

Harold E. Snyder

New Hope, Pennsylvania

New Jersey's Unique Ventnor Foundation†

Medicine, reads our canon of ethics, offers its peculiar benefits to all men. Medicine is thus a truly international discipline, and here in New Jersey we have a unique enterprise which illustrates this.

The Ventnor Foundation is a non-profit educational organization, established in Ventnor (Atlantic City), New Jersey. Its purpose is to help "wage peace" by promoting international understanding and brotherhood. The approach is simple, direct, and down to earth. Its progress is refutation of the feeling that individual effort in such an undertaking is futile.

HOW THE VENTNOR FOUNDATION WAS ESTABLISHED

In 1951, Dr. Hilton Read and his wife, Kathryn, planned a visit to Germany. The Executive Secretary of the Unitarian Service Committee asked Dr. Read to work in a survey of one of its programs among German medical schools. In making the survey, Dr. Read found misconceptions and misunderstandings of the United States. His reaction was both reasonable and emotional. Within his lifetime two wars had been fought and still there was no understanding; if only there was some way in which the doctors and medical students to whom he had talked could see and judge for themselves!

This was the spirit in which Hilton and Kathryn Read tackled the job. They had the encouragement and help of sympathetic friends, the blessing of the State Department in granting visas, and the conviction that in their own small way they were going to help "wage peace."

The German, Swiss, Austrian, Polish and Indian "Exchangees" chosen to come to the United States are recent graduates in medicine. Nominated by their universities, they are interviewed and selected by German associates of the Ventnor Foundation; for Polish applicants, by the Minister of Health of Poland; and for Indians, by Dr. (Mrs.) B. J. Coyaj, a representative of the India Foundation.

Requirements for a successful candidate are that he or she (1) speak good English; (2) be at the top of his class; (3) be an extrovert with an open mind; (4) wish to experience a discipline of medicine, other than that of his homeland; (5) is not an obvious candidate for immigration.

The young German, Indian, Austrian, Swiss and Polish doctors who come to the United States serve as interns for 12 months in 15 hospitals, mostly in New Jersey. The Cooperating Hospitals offer AMA approved internships and assume certain other responsibilities. Each Cooperating Hospital agrees:

1. To contribute a modest amount per year to the Ventnor Foundation to cover administrative costs.

†See editorial, page 52.

2. To advance cost of round trip transportation and landing money for each intern.
3. To pay the Exchangee at least $150 each month and to supply him or her with room, board, uniforms and laundry.

In each of the hospitals one of the staff doctors, known to Dr. Read personally, is charged with the responsibility of keeping in personal contact with the Exchangees; to counsel; to help them adjust to this very different way of life; and to see that they have every opportunity to fulfill the primary reason for their being here—the opportunity to see and judge life in these United States for themselves.

The Exchangees are treated as "Foster Sons" and are welcomed as such into a "Foster Family." They are sent a friendly but realistic orientation letter in which no punches are pulled. The letter spells out the kind of everyday situations of a different way of living to which the newly arrived Exchangees will be expected to adjust. Copies of the *Physician's Handbook* and the *Merck Manual* go off at the same time. This gives the Exchangees a three months' head-start to become familiar with American medical dosage, vocabulary, avoirdupois vs. metric system, and so forth.

Travel arrangements are handled by an Atlantic City agency. They are met at the dock by a representative of the hospital to which they have been assigned. The "Welcoming Committee" is frequently one or more of the Exchangees who have been here for some months. On their arrival at the hospital, the Exchangees find a letter from Dr. and Mrs. Read, with an invitation to visit them in Ventnor and several professionally prepared brochures on American customs and manners. Apart from becoming acquainted, this visit provides an appropriate opportunity to explain our social customs and habits to the Exchangees. They are then plunged into a full schedule of hard work in their respective hospitals. Each Exchangee is required to submit a periodic report about his work and activities.

In October, there is a meeting of the "Family" in Philadelphia. Medical fraternities entertain them as house guests. (One of the eye-opening experiences for the Exchangee is to find American medical students waiting on them in the dining room. This helps to dispel the notion that all American students have an easy time of it, including lots of time to ride around in plush cars).

The October weekend is packed full of activity. Early Saturday morning, the Exchangees meet with Dr. I. S. Ravdin, Vice-President of the University of Pennsylvania in charge of medical affairs, and President of the Ventnor Foundation. Here they watch surgical operations, televised in color on a large teaching screen, and visit a Senior Seminar where they witness the novelty (to them) of a free-for-all discussion between a university professor and his students. During the afternoon, they are introduced to a true American activity: a football game.

They attend a concert of the Philadelphia Orchestra. Eugene Ormandy, its celebrated conductor, holds a reception backstage. They find Dr. Ormandy talking to them in German. The evening ends in one of the fraternity houses with the American interns providing refreshments.

On Sunday, the "Family" attends church. The balance of the day is spent at Haverford, with an opportunity to relax, to talk, and to visit nearby Valley Forge and the Philadelphia Art Museum.

The second weekend is in Atlantic City late in January. Friday afternoon, they are met by friends, each of whom takes two of the Exchangees to their homes for a dinner such as they would normally serve if they were entertaining American friends. On Saturday morning, the Exchangees visit the Children's Seashore House in Atlantic City for orthopedic rounds. Then the Exchangees are given an opportunity to have outstanding men and women picture life in the United States realistically, tell what makes us tick, where we "make a go" of things and where we do not.

One needs only to see the letters received by the Reads after this weekend to be impressed by the extent to which these Forums raise the sights of the Exchangees—as well as their American friends who attend.

Each year about 50 Exchangees have come to the United States.* Within a few months of their arrival, they begin to look about for themselves—and in the process usually acquire a used car. They manage to see the United States far beyond the locality of their hospitals. Many of them visit Florida or the West Coast before returning to Germany. They frequently find it possible to spend a summer in a children's camp—Jewish and Gentile—as Camp Doctors. Concerts and museums are popular. Through the cooperation of the Kiwanis, Rotary, and church organizations, they share in family life in many American homes. Every holiday, they receive more invitations than they can accept.

When the Exchangees leave the United States, the Ventnor Foundation keeps in touch with them—and one another—through a "Foster Family" letter. Officers and friends of the Ventnor Foundation, traveling in Europe, arrange luncheon meetings, "Kaffeetafels," and "open houses" in Europe for Ventnor Foundation's alumni, their families, future candidates, professors and deans. These meetings and reunions are "eye openers" in many ways. Reports of outstanding medical and local community activities of the Exchangees—picked up at these meetings as well as those filtering back through letters to the States—again and again are reflections of their activities in the States.

More than 200 Foundation alumni attended a tenth anniversary in Cologne, featured by a symposium on medical education from an international viewpoint. Distinguished teachers from Europe and the United States attended. Our country was brilliantly represented by Dr. Walter Wiggins of the AMA Council on Medical Education and Hospitals.

The inspiring response of Exchangees after they have re-established themselves is a demonstration of the faith of Dr. and Mrs. Read in the belief that if a person would walk a mile in another's shoes, he would better understand his "brother's" problems.

It is gratifying to see the growing recognition of the efforts to make the Ventnor Foundation—(with but one full-time secretary and a tiny budget)—a channel for better international understanding.

*In 1961, the number was 77.

Where Do Nurses Work?

Where do nurses work? Only 60 per cent work in hospitals, according to the Parke, Davis publication, *Patterns* (July 1960). Industrial nursing is one of the most rapidly growing fields. And the variety of services offered in school health programs creates a demand for nurses in this area of public health. In 1957 there were 9,500 nurses employed full-times in the schools; many others worked on a part-time basis.

An estimated 291,500 nurses are employed in hospitals and related institutions, *Patterns* reports. Second commonest field is private duty nursing, which accounts for 70,000 nurses. An estimated 37,000 nurses work in doctors' offices. And there are now 28,700 public health nurses in this country to "provide health instruction through demonstration and teaching."

This function accounts for 35 per cent of patient-nurse contacts in the public health field, *Patterns* reports. Medical care—that is, giving or securing information; planning for care at a home or institution—accounts for 32 per cent.

Trustees' Meeting: November 19, 1961

Actions taken by the Trustees at their November 19, 1961 session, included the following:

We have been asked by Governor Meyner to support the effort to retain Channel 13 as a New Jersey station.

Action—The Medical Society will support the effort to retain Channel 13 in our State.

Dr. Calvin was appointed to attend the Conference on Disability in Rhode Island, November 29, 1961, as our Society's representative. Dr. Levitas was named as our representative at the Health Careers Service Assembly in Newark. And the appointment of the following was ratified:

AMA Conference on Medical Quackery—Washington, D. C., October 6-8, David B. Allman, M.D.; Ralph M. L. Buchanan, M.D.

AMA Conference on Disaster Medical Care—Chicago, November 4-5, Jack Karel, M.D.

AMA Training Workshop on Medical Self-Help —Brooklyn, October 17-19, R. Winfield Betts, M.D.

It was reported that members of the medical staff of the Newark Beth Israel Hospital had received letters urging them to send patients to the hospital for diagnostic procedures. The Radiologic Society of New Jersey now requests that the Medical Society send to all members and all hospitals a resolution adopted by our Welfare Committee in December 1947 and reaffirmed by the Board in April 1954. This resolution read as follows:

That the sending of ambulatory private patients to hospitals for x-rays, laboratory examinations, and physical therapy treatment be discouraged where adequate facilities are available in private physicians' offices. Nothing in this resolution shall be interpreted as interfering with mass x-rays or studies, or clinic care of the indigent.

Following discussion, during which it was generally agreed that even with the availability of Rider J the Society's position has not changed with regard to ambulatory private patients; that pressure to send patients to hospitals for diagnostic services should be discouraged; and that emphasis should be placed on the fact that the doctor is the one who determines where to send his patients for these services.

Action: The Board reaffirmed its resolution of April 1954. The membership will be informed of the Board's action by individual letter.

Dr. Buchanan directed the Board's attention to the 1961 National Hemoglobin Survey. The College of American Pathologists believes that this survey will stimulate national interest in the accuracy of hemoglobin measurements and lead to regular calibration of photometers used for hemoglobin measurements. Members who wish to participate may do so by requesting the survey sample from the Standards Committee, College of American Pathologists, Prudential Plaza, Chicago 1. Charge for the survey samples, the evaluation report, and the critique of hemoglobin measurements is $10. Questions concerning hemoglobin calibration and standards may also be directed to the Committee.

In a communication from Commissioner Kandle, State Department of Health, it was reported that the National Cooperative Leukemia Study, supported by a grant from the National Cancer Institute, has been completed in New Jersey. The Commissioner extends his thanks to the physicians in New Jersey who submitted data on cases of leukemia and lymphoma in children for this study, and to the Society for its support and encouragement.

Action: Dr. Kandle submitted a brief article on this. Dr. Buchanan suggested, and the Board concurred, that the article be referred to THE JOURNAL and the *Membership News Letter* for publication.

A communication from Lloyd B. Westcott, President of the State Board of Control, expressed gratitude from himself and the Commissioner of Institutions and Agencies for the Society's support of the Bond Issue. He stated, "we will now move as rapidly as possible to translate dollars into desperately needed buildings."

An invitation has been received from the AMA to send representatives to a Conference on Care of the Aged. This is co-sponsored by the American Dental Association, the American Hospital Association, the American Nursing Homes Association, and the American Medical Association. The conference will be held on December 15 and 16, in Chicago.

Action: Dr. Hahn and Dr. Eckstein will attend the conference as the official representatives of the Medical Society, with expenses paid.

POLIOMYELITIS VACCINES

Last September our Council on Public Health recommended that, as an emergency measure, the Executive Committee approve a statement concerning the use of Sabin oral vaccine; that such statement be drafted in cooperation with the State Health Department and be issued as a joint statement from the Medical Society and the State Department; and that it be released to all physicians, local health departments, and daily newspapers of New Jersey.

In this connection the following was approved by our Executive Committee and released through the State Health Department:

The reduction of polio by the inactivated (Salk) vaccine in New Jersey has been effective. The most important task now is to protect all persons, but especially babies and parents of young children with the recommended four doses of Salk vaccine.

Type I and Type II oral vaccines are currently available. The best uses of the oral vaccines appear to be to control Type specific outbreaks and for community wide mass protection of unvaccinated populations. The indications for mass revaccination of already vaccinated populations have not been established.

The Salk vaccine must continue to be used. Both Salk and oral vaccines will find their most appropriate use. One will not displace the other.

It is recommended that:

1. The maximum protection by four doses of Salk vaccine be emphasized.
2. Type I oral and Type II vaccines are to be used in New Jersey primarily to control Type I and Type II outbreaks, should they occur. Type II cases are rare. Type III is appearing with increasing frequency both in New Jersey and the United States.
3. Communities should plan slowly and deliberately, as more data become available, for community educational programs designed especially to reach those not now vaccinated.
4. If Type I and Type II oral vaccines are used now in unvaccinated individuals, they should be followed by a standard course of four doses of Salk vaccine.

IMPARTIAL MEDICAL EXAMINATIONS AND EXPERT TESTIMONY

As directed by the Board, the Special Committee on Medical-Legal Testimony obtained lists of nominees from the four component societies (Essex, Morris, Union, and Warren), and submitted the lists, with its recommendations for the appointment of the panel members, to the Executive Committee.

The Executive Committee unanimously approved a list of 272 nominations for places on the official panels to be made available to the Court as impartial medical witnesses. The chairman directed that each nominee designate be sent a letter informing him of his nomination and soliciting his formal acceptance.

The Board was informed that, as of today, of the 272 nominees appointed 177 had accepted, 5 had declined, and 7 were uncertain. Dr. Greifinger suggested that for those who had declined appointment replacements be obtained and appointed.

Action: The Board authorized the Special Committee on Medical-Legal Testimony to provide nominees as replacements for those who decline appointment. The special committee is authorized to send the list of names to the Court Administrator as soon as possible.

ADVISORY COMMITTEE TO SELECTIVE SERVICE

Notice was received from the National Advisory Committee to Selective Service that William G. Herrman, M.D., had resigned, after 11 years' service, as chairman of our State Advisory Committee. Request was made for submission of three names, one of whom would be appointed by the National Advisory Committee as Dr. Herrman's successor.

Action: The Board approved the Executive Committee's nominations of Jesse McCall, M.D., Luke A. Mulligan, M.D., and Elton W. Lance, M.D., for the appointment of one to succeed Dr. Herrman.

LONG TERM PLANNING COMMITTEE

The Hospital Association has invited The Medical Society of New Jersey to join with

it in sponsoring "a statewide organization to gather facts about hospitals, nursing homes, professional personnel, population needs, the utilization of health services, and other pertinent data necessary to identify the major hospital service areas in the state; and for the use of those organizations in the respective service areas as may be formed for the purpose of planning a coordinated system of health care facilities and services in those areas. Such a state organization should probably be equipped to interpret the facts and data collected and to offer advice and guidance to local planning organizations."

Action: The following committee action was approved: That the Society join the New Jersey Hospital Association in exploring the practicality and feasibility of this proposed statewide organization.

PROGRESSIVE PATIENT CARE WORKSHOP

The Hospital Association would like to sponsor a workshop on progressive patient care (intensive, intermediate, self-help, chronically ill, and home care). The Medical Society is invited to co-sponsor this.

Action: Co-sponsorship of the proposed workshop is authorized; the President and chairman of the Board will name three or four representatives to the joint planning committee.

HOSPITAL ACCREDITATION EXAMINATION

The New Jersey Hospital Association proposed that the Medical Society cooperate to set up a "dry-run" or dress rehearsal survey team that, on invitation, would help unaccredited hospitals in New Jersey prepare for the formal accreditation examination.

Dr. Bedrick stated that a hospital which loses or has its accreditation suspended is given a list of items to be complied with and that detailed information for preparing for the formal accreditation examination is available in booklet form. The American College of Surgeons has a survey team available to any hospital upon invitation. However, Dr. Allman felt that the Medical Society should cooperate with the Hospital Association in this matter. He moved—seconded by Dr. Greifinger, and carried—that the Board approve the proposal of the Hospital Association.

Action: The President and the chairman of the Board will name three or four members to serve on the proposed survey team to assist unaccredited hospitals on invitation.

ADVISORY COUNCIL ON CHRONIC SICK

In a communication from the Commissioner of Health, the Society is requested to submit nominations to the State Advisory Council on the Chronic Sick. Dr. William D. Kimler of Haddonfield is presently serving on the Council, and Dr. Kandle urged consideration of nominating him for re-appointment.

Action: Dr. Kimler is nominated for re-appointment on the Council.

CONFERENCE ON HEALTH CARE OF THE AGED

The U. S. Chamber of Commerce will hold a conference on Health Care of the Aged in New York City on December 18, 1961. The Society is invited to send representatives.

Action: Four representatives will be authorized to attend the meeting with expenses paid. Their appointment is left to the discretion of the President and the Chairman, who announced that the four representatives would be: Drs. Buchanan, Wegryn, and Lloyd, and Mr. Nevin.

PUBLIC AFFAIRS CONFERENCE

The U. S. Chamber of Commerce is sponsoring an Association of Public Affairs Conference. This will be held in Washington, D. C., on January 24-25, 1962. Our Society is invited to send representatives to this meeting.

Action: Attendance of representatives with expenses paid will be left to the discretion of the President and the Chairman.

DEATH CERTIFICATES

A communication from the State Board of Medical Examiners reported that some nursing homes are having difficulty in getting physicians' signatures on death certificates. The State Board desired to alert the Medical Society to this problem. This communication is received and noted.

COUNCIL ON LEGISLATION

Upon individual motions, seconded, and carried—the recommendations contained in the report of the Council on Legislation were adopted. These are on page 97 of this JOURNAL.

Action: The report of the Council on Legislation as circulated to the Board, is approved. The minutes with the Board's actions noted thereon will be attached to the minutes of this Board meeting.

BLUE CROSS OUT-PATIENT ALLOWANCE

In its consideration of a communication from the Hackensack Hospital Medical Executive Board, relating that Board's opposition to the subscriber benefit of Blue Cross which includes two follow-up visits after the original emergency room visit, the Council on Medical Services also studied information obtained from Blue Cross as to how the extension of this coverage came about. The 1953 House of Delegates approved a proposal by Medical-Surgical Plan for extension of out-patient services under the Plan. In order that the patient would be covered for the hospital expenses incurred in connection with the physician's services covered by Blue Shield, Blue Cross similarly extended its out-patient services.

It was the unanimous action of the council that it is in substantial agreement with the Hackensack Hospital Medical Board on this matter.

Action: The recommendation of the Council is approved, and it will be so reported to MSP and HSP.

WORKMEN'S COMPENSATION

The report and recommendations from the Special Committee on Workmen's Compensation were considered and approved by the Council on Medical Services. The council recommends that the following recommendations of the special committee be approved:

A. That the Special Committees on Industrial Health and Workmen's Compensation be authorized to meet jointly with a committee from the New Jersey State Bar Association to explore the meaning and definition of physical disability as applied to physical impairment, as to what the doctor's task is in determining impairment and disability, whether it is possible to divide these two and put disability in the hands of people who understand job evaluation as opposed to physical impairment so that it may be possible then to equate physical impairment with physical disability on the same logical basis; and that, following the conference with the State Bar Association representatives, conferences then be held with the State Department of Labor and with representatives of insurance carriers.

Action: This recommendation was approved.

B. That the Board of Trustees give further consideration to the question of method and rate of payment for injured employees of the State of New Jersey in workmen's compensation cases, and that its special committee follow through on a conference with the State Claims Bureau.

Action: This recommendation was approved.

Dr. Buchanan announced that the Special Committee on State Employees and Workmen's Compensation would be re-activated, that Dr. Greifinger would continue to serve as chairman with Dr. Ruoff and one other member.

AMERICAN COLLEGE OF SURGEONS

Received from the Hudson County Medical Society was a resolution calling for the American College of Surgeons to instruct its Secretary General to cease his repeated, unwarranted and unfounded attacks upon the practice of surgery in these United States; and that the Secretary General be so instructed that his activities be in a constructive rather than in a destructive vein.

This resolution was similar to that which the AMA Delegates had been instructed to present at the 1959 AMA Annual Meeting concerning the previous Secretary General. The resolution was *not* introduced on the basis of its being strategically undesirable for two reasons: (1) No other state delegation seemed interested in taking similar action; and (2) Introduction of the resolution would be tantamount to giving it to the press thus inviting further publicity that might reopen and enlarge upon the initial attacks. However, another resolution was introduced by the New Jersey Delegates at the 1959 clinical session, accepted by the House of Delegates, and referred to the AMA Board of Trustees for referral to the proper liaison committee.

Action: The delegates are instructed to introduce and support the following resolution:

Whereas, in 1959 there appeared in the press and other media of public information a series of injudicious and unwarranted comments disparaging, and casting aspersions upon, the competence of members of the medical profession in general and surgeons in particular; and

Whereas, in certain instances these comments were made by individuals accepted as official spokesmen for recognized and ordinarily responsible specialty groups within the profession of medicine, and were therefore inordinately effective in depreciating the standards and character of medical and surgical services in the United States and in undermining public confidence in them; and

Whereas, in consequence, the New Jersey Delegation introduced a resolution (No. 15) in the AMA House of Delegates—meeting in Dallas, Texas, in December, 1959—which called upon the House of Delegates to direct the American Medical Association, by the establishment of effective liaison with such specialty groups, to achieve a rapport "to insure that the remarks and writings of all authoritative and quasi-authoritative spokesmen will at least be consonant with fact and truth, and therefore consonant with the genuine best interests of the profession and the public"; and

Whereas, having been assured that the AMA Board of Trustees had already "established liaison committees with national medical societies," the Reference Committee on Miscellaneous Business recommended—and the House of Delegates adopted—that "this resolution be accepted and referred to the Board of Trustees for implementation by the appropriate liaison committee or committees"; and

Whereas, in recent months there have been a renewal and reiteration of such deprecatory comments—as uncalled for as they are unfounded and unjustified—with further and intensified damage to the public image of the physician and surgeon; now therefore be it

Resolved, that this House of Delegates, in the interest of the public and of the members of the medical profession of this country, who have achieved and who maintain the highest professional and ethical standards in the world, call upon the Board of Trustees of the American Medical Association to carry out the mandate given two years ago and to take instant and effective steps to defend and safeguard the public and the profession against irresponsible attacks from groups or individuals bent upon doing them undeserved injury.

COUNCIL ON PUBLIC HEALTH

The following recommendations, adopted by the Council on Public Health at its meeting on September 27, 1961, were referred to the Board for consideration and action:

1. That the Special Committee on Cancer Control be authorized to circularize all New Jersey hospitals now listed as not having tumor registries or committees on cancer, to learn the status of the cancer programs in these institutions.

2. That the Special Committee on Cancer Control be authorized to send a questionnaire to all functioning tumor registries to learn the name or type of record system utilized; standardization of forms will facilitate institution of a central registry.

Action: Both requested authorizations were granted.

CONSERVATION OF VISION

The following program was approved:

1. Initiation and organization of the school eye health program as approved last year.
2. Completion of the 1961 Eye Health Screening Program.
3. Continued study on contact lenses.
4. Continued study on the relationship of optometrists to eye care.
5. Continued support of the Medical Technicians Bill (S-72).

CHILD HEALTH

The Special Committee on Child Health feels that some closer tie should be established with New Jersey school physicians, and it is recommended that—if feasible—the school physicians become a subsidiary group of the special committee until some formal organization of school physicians is established; and that an exploratory meeting of the special committee with county society school physician representatives be held sometime this fall.

Action: The recommendation is approved, if practicable.

The Special Committee on Child Health wishes to apply for space in the educational exhibits at the 1962 annual meeting; the exhibit will be titled "School Failures Due to Learning Disabilities;" an appropriation from the budget of the Council on Public Health is requested in an amount not to exceed $150.

Action: This recommendation is approved.

The following recommendation was sent to the Executive Committee immediately following the meeting of the council; and Dr. Kandle offered the facilities of the State Health Department for printing and mailing the statement.

That, as an emergency measure, the Executive Committee approve a statement concerning the use of Sabin oral vaccine; that such statement combine the salient points in the Essex report and the State Health Department release; that such statement be drafted in cooperation with the State Health Department and be issued as a joint statement from the Medical Society and the Department; and that it be released to all physicians, local health departments, and daily newspapers of New Jersey.

Action: The Board approved the action taken by the Council on this matter.

The Special Committee on Child Health wishes to conduct a state-wide symposium on Childhood Accident Prevention. The following list of organizations should be considered tentatively as invitees to cooperate in the program: New Jersey State Safety Council, New Jersey Congress of Parents and Teachers, State Department of Education, State Department of Health, New Jersey Chapter of American Academy of Pediatrics, and the Junior Chamber of Commerce.

Action: The project is approved; and expenses will be authorized in any amount not to exceed $100.

CHRONICALLY ILL AND AGING

The following program was approved:

1. Establishment of a library of relevant informational material under the auspices of the special committee.
2. Convocation of a general meeting of representatives of county society commitecees on the chronically ill and the aging.
3. Development of a group of speakers from the Society's committee to work—at state and county levels—to mold and effectuate medical leadership.

AIR POLLUTION

The Air Pollution Commission, a separate legislative body, has called upon the State Health Department to establish codes for air pollution and provide technical guidance thereto. The Commission, through Dr. Kandle, has requested the establishment by the Medical Society of an advisory committee to provide medical guidance. The council approved the request and recommends that an Advisory Committee on Air Pollution be established by The Medical Society of New Jersey.

Dr. Buchanan suggested that air pollution be considered within the scope and function of the Council on Public Health, and that a subcommittee of the council be appointed to serve in an advisory capacity to the Air Pollution Commission.

Action: The suggestion of the President was approved. The report of the Council on Public Health as modified was approved.

ANNUAL MEETING

The Committee on Annual Meeting has approved the following suggestions offered by the section officers:

(A) On an experimental basis at the 1962 annual meeting, the election of section officers will be scheduled the first ten minutes on each program.

(B) On an experimental basis, the mid-session intermission to visit exhibits will be eliminated. Scientific programs—originally scheduled for two hours and 45 minutes each—will be cut to two hours and 15 minutes; and the visit to exhibits will be scheduled at the end of each program.

(C) The committee directed that a copy of the advance program (usually the February *News Letter*) be sent to the president of each hospital medical staff in New Jersey, together with a request that the scientific sessions be brought to the attention of the medical staff at a staff meeting, and that staff members be urged to attend the annual meeting.

(D) The committee directed that the program be sent to medical staffs in Philadelphia and New York City, together with an invitation to their staff members to attend the annual meeting, with special notation that there is no registration fee for out-of-state physicians.

(E) As another means of publicizing the annual meeting and possibly increasing the attendance, the committee agreed that advance programs be sent to the medical societies of New York, Pennsylvania, Connecticut, Maryland, and Delaware, with a request that they publicize the scientific sessions in their Journals; together with an invitation to their members to attend the meeting, specifically noting that there is no registration fee for out-of-state physician-guests.

(F) The committee concurred in Dr. Stein's suggestion that a double postal card be inserted in the advance program to solicit questions from members for presentation to and discussion by program panel members.

It was suggested that a double postcard in the advance program (published as a 12-page issue of the *Membership News Letter*) would not warrant the extra effort and cost involved, and could result in a delay in publication and mailing of the program. The opinion was also expressed that the number of replies would be negligible. It was finally suggested that, instead of a double postcard, an item soliciting questions from the membership be published in the *Membership News Letter*.

Action: The foregoing recommendation was approved in lieu of Dr. Stein's suggestion.

1966 CELEBRATION

With respect to the 1966 celebration, the Annual Meeting committee adopted the following recommendations: (A) That a yearly appropriation from the annual meeting reserve account (to be fixed by the chairman of the Committee on Annual Meeting), be made available to the Society's Historian-Archivist, Dr. Rogers, for the next four years to cover expenses (research, clerical, etc.) in bringing the history of the State Society up-to-date; and (B) In recognition of the efforts of component societies which want to preserve for posterity historical knowledge of medical efforts in their counties, State Society records would be made available to representatives visiting headquarters for historical research culminating in the meeting of 1966. It is also urged (C) that every assistance, except financial, be afforded component societies in preparation of local histories.

Action: The recommendations of the Committee on Annual Meeting were approved.

RETIREMENT PLAN

The AMA has deferred any action with respect to a national group retirement program until favorable action by the Congress was taken on HR-10 87th Congress (Keogh). The Retirement Plan Committee—at its meeting on September 24, 1961—unanimously agreed that, as recommended by the AMA, any action on a retirement program on a state level should be deferred until action is taken on HR-10.

MEDICAL DEFENSE AND INSURANCE

At its meeting on October 1, 1961, the Commmittee on Medical Defense and Insurance considered a communication from the American Liability Insurance Company requesting that consideration be given to amending our Society's Constitution and Bylaws to permit the appointment of lay members with full voting privileges to county medical review and advisory committees.

These committees are concerned with the loss control program in connection with the Society's program for professional liability insurance. One of the values of having lay members on these committees with full vote would be acceptance by Society generally, and particularly the legal profession, of the decisions of these committees.

Our current State Constitution and Bylaws stipulate that only members of the Society serve on councils and committees; and that non-members may be designated as advisors, observers, or consultants (without vote). County constitutions and bylaws generally follow this pattern, too.

The committee held no firm conviction in the matter, and *recommended* that the request be referred to the Board of Trustees for decision.

Action: The request of the American Mutual Liability Insurance Company was denied.

NURSING EDUCATION

The 1961 House of Delegates had directed that a Special Committee on Nursing Education be appointed to study nursing education from the standpoint of recruitment and make recommendations. This Special Committee on Nursing Education unanimously adopted the following:

"The primary need is for more nurses. Increase in the supply of nurses will be realized in proportion to increases in effectiveness of recruitment.

"Recruitment will be stimulated if: (1) Without reflection on three-year programs, all hospitals interested should be encouraged to adopt two-year programs that will qualify

the candidate for licensing examination; (2) This should be followed by a one-year internship *with pay* in the hospital of the nurse's choice; (3) There should be realization of higher and more equitable levels of compensation for graduate nurses working in hospitals on a salary basis; (4) Efforts should be aimed at the reclamation of graduate nurses who have discontinued the practice of nursing, of student nurses whose training was interrupted by making available to them, without charge, refresher and other instructional courses; and (5) There should be re-examination of the present entrance requirements for schools of nursing.

Action: Recommendations of the Special Committee were approved.

MEDICARE

Two supplemental Medicare agreements have been received. Both have been executed by Medical Service Administration. Supplemental agreement 3201 will terminate the practice of publishing and transmitting to physicians copies of the schedule of allowances for physicians' services. Execution of the agreement by the Society is required.

Supplemental agreement No. 3202—concerning reimbursement for advertising costs—also requires execution by the Society.

Action: The appropriate officials of The Medical Society are authorized to execute the agreements.

CONGRESS ON OCCUPATIONAL HEALTH

The following conclusions and recommendations were received from Dr. Caldwell, who attended the Congress as the Society's official representative:

(1) A note of appreciation should be sent to the Colorado Medical Society; (2) A similar note should go to the AMA Council on Occupational Health; (3) Our Medical Society should continue to be represented at these meetings; and (4) Certain recommendations were made with respect to the State Chairmen of Industrial Health or Occupational Medicine. The position taken by a group of such chairmen was as follows:

(a) *Opposed* to the State chairmen organizing in the form of election of officers.

(b) *In favor* of having the chairmen of the Industrial or Occupational Health Committee of the State Medical Society in the state where the Annual Congress on Occupational Health is to be held as chairman of the group of State chairmen attending the Congress.

(c) *In favor* of a three-times-a-year newsletter from the AMA Council on Occupational Health to each State chairman.

(d) *In favor* of a closed but informal meeting of State chairmen at the place of, but just prior to the opening of the Annual AMA Congress on Occupational Health.

(e) Regional Meetings of State chairmen and council are helpful and such regional meetings should be continued.

Action: Upon individual motions all the above recommendations were approved.

Dr. Caldwell suggested when the AMA Council holds its Regional Meeting in this area, it should be attended by a representative from The Medical Society of New Jersey.

Action: No action on this was taken now, since representation at meetings is determined by the Board as invitations are received.

Dr. Caldwell also suggested that interim reports to State chairmen from the AMA Council be shared with our Committee on Workmens Compensation.

Action: This was approved.

Dr. Caldwell suggested that our Committee on Industrial Health proceed with its plan to prepare, for considered New Jersey Medical JOURNAL publication, a series of *brief* articles on Occupational Health activities and interests.

Action: This recommendation was approved.

The chairman suggested that county medical society occupational health or compensation committee members be invited to attend as guests the meetings of the State Society's Committee on Industrial Health.

Action: This recommendation was approved.

Dr. Caldwell suggested that members of the State's committee offer to talk before county society meetings on matters of industrial health.

Action: This recommendation was approved.

Also included in the report were nine points which Dr. Caldwell suggested be given consideration by the Special Committee on Workmen's Compensation. One was that: In compensation cases the employer who foots the bill should retain the right to designate the diagnosing and treating physician. Dr. Greifinger emphasized that AMA policy (which this Society has repeatedly endorsed) was that every patient should have free choice of physician.

Action: The nine points are referred to the Special Committee on Workmen's Compensation with notation of the Society's position concerning free choice of physician.

DISPUTED MSP AND HSP CLAIMS

Since the formation of the advisory committee by the Society, a new type of disputed claim has arisen. Hospital Service Plan, in administering the Supplemental Benefit Section (*major medical*) of the Government-Wide Service Benefit Plan (Federal Employees Program), is charged with the responsibility of paying physicians for "reasonable and customary charges." The physician whose bill appears to be excessive is given an opportunity to adjust his fee to that which is considered reasonable. This approach is liberal enough to handle most situations. Occasionally (eight cases in six months) a claim arises which appears to be completely unreasonable and not "customary"; yet the physician is unwilling to adjust his fee. At present, such cases may be referred to the Administrative Agency for review in Washington, D. C. Dr. Alfano has said the MSP would welcome the services of the committee to act in an advisory capacity prior to forwarding claims from members of the Society to an outside reviewing authority.

Action: The advisory committee is *not* authorized to include within its scope of function review of disputed claims under the program of major medical coverage for federal employees.

Dr. Bowers requested that Dr. Alfano be informed of the Board's action, and that he be reminded that there is available within this State the judicial mechanism which handles such cases; and suggest that disputed claims be referred to the proper county society judicial committees for review.

SERVICES FOR THE HANDICAPPED AND CHRONIC ILL

Received from Dr. Elias, the Society's representative on the Directory Planning Committee, was a report outlining the committee's proposal for compilation and publication of the directory. The estimated over-all cost was figured at $20,000. The Medical Society was requested to co-sponsor the directory; to provide funds (suggested amount $7,000) toward the initial compilation and publication; the published directory to be provided without charge to Society members; and to serve in an advisory capacity in the compilation and publication of the directory information.

Action: These requests were denied. The 1961 House of Delegates had disapproved a request for an appropriation of $10,000 to defray the cost of compiling a directory under the auspices of the Medical Society alone.

TRAFFIC SAFETY

Mr. Nevin presented the following report from the meeting of the Committee on Traffic Safety held on November 12, 1961. The committee considered the desirability of making digests of an article available for distribution to patients at the Society's expense. The article was "A Doctor Warns of Medicines That Menace Your Driving" by Dr. Seward E. Miller, Chairman, AMA Committee on Aspects of Automotive Safety, published in *This Week* magazine, in August 1961.

Action: The committee unanimously disapproved the proposal. It was the opinion of the committee that the limited good the article might do is decisively outweighed by the damage it does to the patient's confidence in his physician and—by imputation—to the judgment, discretion, and professional responsibility of the physician himself. It is the duty of the physician who prescribes medications properly to warn his patients individually. This warning, the committee contends, should not be given by means of ill-directed, generalized, scare-head articles. The committee urged that the Board inform the AMA of this point of view, to the end that further such articles will *not* be produced and released by the AMA. These recommendations were approved.

The committee recommends that the Board appoint a three-member advisory panel to function at state level to assist the Director of Motor Vehicles in evaluating the reports of examinations made by physicians concerning suspect cardiac drivers whose licenses are be-

ing considered by the Director. This was approved by the Board.

STATE BOARD OF MEDICAL EXAMINERS

The Board was informed that the term of Daniel F. Featherston, M.D., as a member of the State Board of Medical Examiners, would expire on November 20, 1961, and nominations for submission to the Governor were requested.

Action: The following nominations were approved in the order of preference indicated: (1) Daniel F. Featherston, M.D., Asbury Park; (2) Lloyd A. Hamilton, M.D., Lambertville and (3) Raymond A. Taylor, M.D., Lakewood.

NEW JERSEY HEALTH CAREERS SERVICE

Received was a request for a contribution in support of the continuation of the activities of the organization. The Board authorized a $100 contribution.

STATE SAFETY COUNCIL

Received from the Council was a request for a $50 contribution for three years toward continuation of the Council's activities. Also received and noted was a communication from Governor Meyner endorsing the activities of the Council and urging financial support.

Action: A three year $50 contribution was authorized.

FLUORIDATION

Received from the Metuchen Junior Chamber of Commerce was a request for a letter stating the official attitude of The Medical Society towards fluoridation and for any suggestions.

Action: The Board directed that the group be informed that the Society's position was one of approval of a fluoridation program.

MEMBERSHIP DIRECTORY

Dr. Wegryn suggested that a Committee on the Directory be appointed to deal with policy questions concerning the membership directory.

Action: The suggestion was approved and a committee will be named.

LEAVE OF ABSENCE

Dr. Jehl reported that his Surgical Hospital Unit has been called to active duty, and that he may thus be unable to perform his duties as a member of the Board. He requested a leave of absence until his status is determined; or, if it was deemed desirable, he offered to submit his resignation.

Action: Dr. Jehl will be granted a leave of absence until his status is determined. A letter will be sent to Dr. Jehl wishing him well and hoping for his early return.

Medicare Claim Forms Revised

The Medicare claim form DA 1863 (Statement of Services Provided by Civilian Medical Sources) has been revised. A supply of the new revised claim form, now called DA 1863-2, will be supplied to physicians through normal issuing channels. You may continue to *use the old DA 1863 form until your stock is exhausted.* Then the revised forms will be issued on your request sent to Medical Service Administration, 500 Broad Street, Newark 2, N. J. (Phone: MA 4-2600).

The Original DA 1863 form was designed to meet the requirements of hospitals and dentists as well as physicians. The revised form DA 1863-2 is buff colored and is for physicians and dentists only; the hospital claim form (DA 1863-1 which is blue) is used only for hospital Medicare claims.

Council on Legislation

A regular meeting of the Council on Legislation was held at the Executive Offices on November 1, 1961.

At its meeting on July 16, 1961, the Board of Trustees approved the report of the Council (meeting on June 21) as amended, as follows:

(a) The Board modified the Council's recommended positions from "no action" to "approval" concerning A-647, A-648, A-649 (revising Mental Health Laws and commitment procedures)—on the basis of the full study and report of the Legislative Analyst, made after the June 21st meeting of the Council.

(b) The Board modified the Council's recommended position from "approval in principle" to "no action" concerning A-654—because the bill had been withdrawn at the request of the State Board of Medical Examiners for further study and report.

WELFARE SERVICE LEGISLATION

A-10—*Results of correspondence with allied professions soliciting their support of a proposed amendment* . . . As directed by the Council at its preceding meeting, the Executive Officer made contact with the allied health professions, acquainted them with the Society's position concerning A-10, and solicited support of the proposed amendment to name specifically in the legislation the "designated organizations" whose membership shall comprise the "Advisory Committee on Medical Assistance." Acknowledgments were received indicating that the support was forthcoming.

A-669—*Re-evaluation of Society's official position* . . . On August 28, A-669 passed unanimously in the Assembly. Since A-669 was introduced as a substitute for A-10, it can be assumed that A-10 (which the Society has supported as "a more comprehensive public medical care program" than A-669) will not come out of Assembly committee this year.

In view of this and the desirability of the earliest possible implementation in New Jersey of the Kerr-Mills Law, the Council unanimously recommended that the Society now modify its position concerning A-669 to one of active support.*

The Council also recommended that the Society's official position concerning A-10 be retained as is: "approval . . . with active support upon introduction of recommended amendments."*

STATE LEGISLATION

The Council considered the following bills of medical interest and recommended the positions indicated:

S-235 *Sandman*—To modify certain required qualifications for veterans applying for licenses to practice medicine and surgery. *Disapproval, with active opposition if bill moves* . . . because the legislation serves no constructive purpose but would restrict present discretionary powers of the Board of Medical Examiners with disadvantage to candidates and disservice to the public interest.*

S-239 *Ridolfii, Grossi, Cowgill, Lynch*—To make a person who steals any narcotic drug from the person of another "with or without his knowledge" or enters any store, room, office, airplane, ship, etc. with intent to steal any narcotic drug or "steals any narcotic drug of another" guilty of a high misdemeanor with penalty of $5,000 fine or 15 years imprisonment or both. *Approved.**

This is a companion measure to A-748 and is identical in language.

A-741 *Barkalow, Matthews*—To make any person who discharges or permits the discharge of waste, debris or refuse into the coastal waters or tidal water bays of this state from any vessel and which might tend to pollute such waters a disorderly person. *Approval.**

A-742 *Barkalow, Matthews*—To regulate the use of "marine toilets" on "watercraft." *Approval.**

A-748—To make any person who steals narcotics or breaks or enters any enclosure, any store, room, ship, airplane, with intent to steal narcotics, guilty of a high misdemeanor. *Approval.**

This measure is identical with S-239.

A-753 *Smith*—To prescribe standards and regulate the sale, distribution, and handling of special frozen dietary food. *Approval.**

A-757 *Deamer*—To permit county hospitals to accept private patients who cannot obtain admission within a reasonable time to a voluntary hospital in a county. *Tabled until next meeting.*

It has been reported to the Legislative Analyst that this was prepared exclusively for Bergen Pines Hospital. However, the provisions would apply to *all* "county hospitals and other county institutions" and might affect voluntary private hospitals. Question was also raised concerning what is embraced in the term ". . . within a reasonable time . . ."

In view of the implications of this legislation, the Council directed that inquiry be made

*This action or position was approved by the Board of Trustees November 19, 1961.

of the Bergen County Medical Society, New Jersey Hospital Association, and the Society's Medical-Hospital Liaison Committee concerning their attitude toward this bill.

A-759 *Kijewski, Brady*—To authorize the formation of corporations not for profit, for the purpose of providing health centers. *Disapproved.** . . . because the bill is loosely drawn and its purposes unclear.

This bill is similar to A-700, introduced by the same sponsors, concerning which the Society's official position is the same as recorded above. Our Legislative Analyst will make inquiries concerning this bill to ascertain the purpose behind its introduction.

A-760 *LaMorte, Sarcone, D'Aloia, Tate*—To limit the time for bringing actions at law by parents or guardians on behalf of minors under the age of 21 derived by reason of an injury to such minor. *Approved.**

A-762 *Brady*—To permit the State Commissioner of Health to set up regulations for ocean bathing with the view of affording protection against sharks; provides that municipal officials shall comply with such rules and regulations. *No action.**

While the Council approved the purpose of this bill, there has developed within the government, dissention as to *who* shall have the responsibility for this legislation. For this reason, the Council unanimously agreed to take "no action" at this time.

PROPOSED LEGISLATION

The Council considered the report of the Legislative Analyst concerning items referred to him at the preceding meeting.

(1) *To amend the School Health Law, to permit any licensed physician to certify the physical fitness of a minor applying for working papers* . . . Under present law only a school medical inspector may so certify.

The Council unanimously approved the proposed draft as amended: delete "in this state" where twice it appears in Section 3 of the draft. Approved.*

(2) *To amend the Beadleston Act, providing for special educational services for emotionally and socially maladjusted pupils,* to include the school physician among the members of the child study team provided in item 2 of this law; and to provide "psychiatric" rather than "psychologic" treatment of the disturbed children; and to make such treatment the responsibility of the "family and appropriate family physician and/or consulting psychiatrist" rather than the school or county child study team, as provided in item 3 of this law.

The Council tabled this proposed legislation for further study. The proposed amendments were recommended by the Special Committee on Child Health, through the Council on Public Health.

(3) *To amend the Medical Practice Act, to preclude optometrists fitting contact lenses* . . . Since the time of this referral to the Council by the Board of Trustees, the Attorney General has declared (formal opinion, 1961, No. 8) that the fitting of contact lenses by optometrists is within their scope of practice under the law (of 1954). At present, optometrists are fitting contact lenses, and there has not been demonstrated any liability on the part of the public because of this practice. In the absence of such proof, the Council could see no justification for the legislation suggested by the Board. It therefore, deferred consideration of the proposed legislation.

If it is ever demonstrated, by documented proof to the Council's satisfaction, that the public is endangered by optometrists fitting contact lenses, the Council will then consider the proposed amendment to the Medical Practice Act. In the Council's opinion, such is not the case at present.

CHIROPODY LAW

By invitation of the Council, Robert Stess, D.S.C., chiropodist-member of the State Board of Medical Examiners, was invited to attend the Council's meeting. He was accompanied by three representatives of the New Jersey State Chiropody Society.

The Council presented to the chiropodists its basic conclusions (approved by the Board at its meeting on July 16) that "there is no justification for the extension of the scope of chiropody to permit surgery." Dr. Stess said that the chiropodists were *not* asking for extension of surgical privileges but were merely seeking clarification of privileges to protect them in areas where insurance or workmen's compensation claims question their propriety.

The chiropodists, therefore, formally requested that The Medical Society of New Jersey modify or clarify the present chiropody law in any manner it sees fit, to enable chiropodists to treat the following:

(1) Osteomyelitis of the phalanges due to local infectious origin.

(2) Tendon transplantations in the metatarsal area of the great and small toe (involving toe function).

(3) Bone resections in metatarsal bones and phalanges.

(4) Simple uncomplicated fractures of the toes, requiring only supportive dressing.

(5) Dislocations of metatarsal-phalangeal joints.

(6) Treatment of congenital deformities of the toes and forefoot excluding clubfoot, et cetera (Medical Society to enumerate).

The Council agreed to accept these items for consideration and to convey to the Board of Trustees its willingness, with the Board's permission, to explore further the possibilities of modifying the chiropody law, in light of this new request.*

CORRESPONDENCE

Herbert L. Goodman, M.D., Chairman, New Jersey Blood Bank Commission, asked that an exploratory conference be held to decide upon future recommendations for the control of blood banking in New Jersey. Such a conference was scheduled for November 1, 1961, to which had been invited representatives from the New Jersey Society of Pathologists, the New Jersey Blood Bank Commission, the Department of Health, and The Medical Society of New Jersey.

Samuel M. Diskan, M.D., Chairman, Special Committee on the Conservation of Vision, objected to the Council's wording in disapproving A-531.

Attorney General David D. Furman acknowledged the Society's support for the proposed amendment to the Medical Practice Act to extend for five years the residence and intern training period.

H. Grubin, M.D., President, New Jersey Society of Pathologists, asked the Medical Society to oppose S-150 as "detrimental to the public interest."

Robert A. Enlow, Director of the AMA Circulation and Records Department, asked that the Society consider giving gift subscriptions of *Today's Health* to its state legislators at a 50 per cent rate of $1.50.

Action: The Council unanimously agreed to recommend that a gift subscription be given, with the compliments of the Society, to each state legislator, starting with January of 1962.*

Eye Health Screening Program

In September 1961, the Special Committee on Conservation of Vision reported on an Eye Health Screening Program. Here is a summary:

	1960	1961	Change Per Cent
Participating centers	58	60	+ 8
Number screened	5496	7426	+35
Negative	51%	54%	+ 3
Positive	49%	46%	— 3
Of those screened:			
Tonometry positive	6.6%	5.5%	— 1.1
Visual acuity positive		40%	
External inspection positive		7.1%	
Ophthalmoscopy positive		10.5%	

A detailed listing showing the findings in each of the 60 centers is available on application to the Executive Offices of the Medical Society, Box 904, Trenton 5, N. J.

Leukemia Study

Your cooperation is requested in a study of chronic myelogenous leukemia being conducted by the National Cancer Institute at the National Institutes of Health, Bethesda, Maryland.

Referrals of patients with chronic myelogenous leukemia are needed, including some treatment refractory patients with high white blood cell counts and platelet counts, for studies of newer chemotherapeutic agents and as a source of white cells and platelets for *in vitro* and *in vivo* study. Accepted patients will be hospitalized for eight to 12 weeks.

Physicians who wish to have their patients considered for the study may write to the Chemotherapy Service, Medicine Branch, National Cancer Institute, Bethesda 14, Maryland.

Or, you may telephone Bethesda, Maryland, 496-4251 and ask for Dr. Paul Carbone.

Proposed Relative Value Index for New Jersey

IRVING KLOMPUS, M.D., Bound Brook*

The raised eyebrow is an identifying feature of the medical practitioner. If we were not born skeptics, we have become such through training and experience. We question the discoveries of the laboratory scientist only slightly less than the optimistic certainties of the detail man and usually act as if we're all from Missouri—as they used to say. We want to be shown.

Unfortunately, the doubting Thomas in us sometimes becomes our master, and we remain skeptical even after the proof is in. Because I had to overcome many doubts myself before accepting the soundness of the Relative Value Index (RVI), I should like to report a dialogue between the skeptic in me and my informed conviction.

Skeptic: What is this RVI you are trying to promote? Why have you been going to meetings and talking it up like a salesman?

Informed: I'm the compulsive type, I guess. Once I get an idea through my thick skull, I try to pass it on even though I may bore my listeners. RVI is concerned with medical economics. It's a guide and can be a protection. It lists the commonly-done medical procedures, each preceded by an identifying number and followed by a number expressed in Relative Value Units.

Skeptic: Which is a polite way of describing a fee schedule. Mention those words to a bunch of doctors and they might get emotional.

Informed: But it's definitely *not* a fee schedule. There's not a single dollar in the list. That's the whole point.

Skeptic: Who sets this list up?

Informed: Doctors do, and only doctors. It has been found expedient to use identifying procedure numbers and names for procedures that are standard in Blue Shield.

Skeptic: O.K. But what is this unit and what is its value?

Informed: Value! There you go again. This isn't a unit of stock I'm talking about. We put our own value on it. But let's go slowly and talk about ham and cheese sandwiches rather than medical fees.

Skeptic: Why ham and cheese sandwiches?

Informed: Because I eat them for lunch every day. Driving down to Atlantic City to a meeting a year or so ago, I stopped for lunch and had one, and I suddenly got a new perspective on RVI.

Skeptic: I knew the whole idea had hallucinatory elements in it. What were you drinking?

Informed: Coffee, old boy, and that's part of my story. Ham and cheese sandwiches at my hospital lunch room cost forty cents and coffee is ten cents. In Atlantic City, a ham and cheese sandwich was sixty cents and coffee, fifteen cents. On the road, twenty and five cents, respectively. Let me list that.

	Road	Hospital	Atlantic City
Sandwich	20c	40c	60c
Coffee	5c	10c	15c

As you see, the prices are all different but the ratio between coffee and sandwich price is always the same.

Skeptic: All right. I don't need a course in advanced mathematics to see the one to four relationship. So what?

Informed: The "So What" is most important. No one tells any of these places what to charge; still there is a discernible ratio between cost of sandwich and coffee. I said nothing about quality, service, availability, or anything qualitative. Still, there is a definite, quantitative ratio in the cost of these necessities.

Skeptic: Medicine is a necessity, and everyone charges what he wants to charge. So why should we bother with RVI?

Informed: One second. If thousands of doctors were polled as to the fees for certain services rendered under average, ordinary conditions, it might then be possible to determine ratios between, say, the cost of an appendectomy and that of an incision and drain operation; or between an office call and a prolonged visit at a hospital for a severe emergency medical case.

Skeptic: O.K. There's a relationship. Continue.

Informed: Very well. Let me show you this list, which I happen (by mere chance) to have in my pocket. This is from the 1961 Nebraska RVI.

		Units
9001	- Office visit, initial routine, New Patient. History and Physical	5
9004	- Following office visit, routine	2.5
9011	- Home Visit. Routine, new	6

Skeptic: What is a unit worth in Nebraska?

Informed: Now don't go getting emotional so soon! The basic unit can be anything the individual doctor decides. The general 'medical market place' will set him straight by either a huge influx of patients if he's too cheap or a sudden dearth of patients if he's too high. However, the uses of the RVI by an individual doctor are quite limited except in the situation where he has done some procedure different from his usual practice and might refer to a scale to see if his contemplated fee is in line. If he is to defend a fee before a judicial committee, he might use the RVI to see if his fee is in proportion to his usual charges.

*Dr. Klompus is chairman of our Council on Medical Services. This article is published in accordance with recommendation of the Board of Trustees at its December 1961 meeting.

Skeptic: If this RVI isn't for the ordinary every-day use of a doctor, what good is it?

Informed: If we could go back to the good old days and have a doctor-patient relationship, I would agree. But we have encouraged third-party participation in the economics of medicine. I mean Blue Shield, Medicare, Aged and Welfare Care, private insurance, and workmen's compensation insurance. Every doctor has some involvement with these plans. Being professional and not business men, we are pretty poor bargainers and are at a disadvantage in dealing with these third parties. There is no means, other than a RVI, by which a proposed fee schedule can be tested for fairness to the doctors concerned and fairness to the purchasers of our services through the many types of plans available.

Skeptic: You mean we are going to solve all our economic problems with the RVI?

Informed: Don't talk like a quack. W are not discussing panaceas, economic or any other kind. I simply said that we're in a better position *vis a vis* third-party medical payment with RVI.

Skeptic: But couldn't someone (say, the government or a union) arbitrarily set the value of the unit in dollars. Where would you be then?

Informed: That sounds like a last-ditch argument. If the government ever does try to get into medicine, we're better off with unit values and ratios which have been set by doctors than with those set by politicos and bureaucrats. If I were in a committee discussing a fee schedule for insurance and someone tried to tell me what the fee should be, I would walk out. This is the only item that can be negotiated and then ratified by the doctors themselves. Besides, there's nothing sacred about any relative value index. We made it. We can destroy it. The list can be changed each year as procedures become easier or more familiar, or as newer, more difficult technics come into use.

Skeptic: If all this is true, why isn't it in general use?

Informed: Why are you a skeptic? The AMA has done everything in its power to urge the states to adopt a RVI. The AMA feels rightly that each state has conditions unique unto itself and any such plan had best be adopted by the individual state.

Skeptic: How many states have a RVI?

Informed: As of 1961, sixteen. And almost all the rest are considering it. *Not one state has abolished it after adoption.* California has revised its plan three times. The New Jersey Council on Medical Services has polled the various states on their experience with RVI. Want to hear what they say?

Skeptic: Just give me the consensus.

Informed: Montana says "We believe that it serves a useful and valuable purpose."

Kansas writes "We decided to revise our schedule so we surveyed our membership. Seventy per cent of the doctors answered. Our survey and that of the California RVI were so close we decided to use that one."

South Dakota: "In all, we feel that the advantages outweigh the disadvantages."

Nebraska: "The RVI seems to be of very definite value and we do not believe that there are any real disadvantages accruing from its use."

Iowa says that the "primary complaint has been from internists and pediatricians, because of incomplete listings of their procedures. The vast majority of physicians in Iowa have accepted RVI."

California boasts: "California originated the RVI and our experience has been excellent."

Utah writes: "RVI adopted four years ago has proved extremely satisfactory."

No state has canceled. I'd say it was a convincing picture, wouldn't you?

Skeptic: I've never heard of polling the doctors in New Jersey. Did you?

Informed: No. We used the California and other plans as a guide and called in twenty-one specialty societies and GP groups as consultants. This was a short-cut for economy reasons but one considered completely adequate for setting up the RVI. The first revision, when necessary, would follow a poll of the doctors.

Skeptic: All right. I'll go along. Not that I believe everything you've said; but since RVI can be revised or dropped next year if we don't like it, what's the difference? Besides, I'm from Missouri. This will give me a chance to be shown!

Informed: Good. To paraphrase a prominent American poet, since freedom consists of pulling easily together in harness, let's make sure the harness is comfortable and the load light.

Any other skeptic is invited to ask questions which we shall attempt to answer in a following article. Send your queries to Council on Medical Services, P.O. Box 904, Trenton 5, N. J.

Announcements

Institute in Philadelphia

The Philadelphia County Medical Society will hold its Annual Graduate Institute at the Bellevue-Stratford Hotel, Philadelphia, March 13 through 16, 1962. Topics covered include:

Cardiovascular disease; cerebral vascular disorders; pulmonary disease; recent advances in cancer; newer laboratory procedures; virus diseases; current pediatric problems; gastro-intestinal problems; renal disease; social and economic problems of medicine; atomic medicine; current problems in surgery; and metabolic disorders.

In addition to authorities from local teaching institutions, several out-of-town guest speakers will be on the program. Dr. Edward Annis, representing the American Medical Association, will be the featured speaker on Thursday afternoon, March 15. Many new scientific exhibits will be displayed. This whole seminar is approved for credit by the American Academy of General Practice.

Write to Dr. Malcolm W. Miller, 301 South 21st Street, Philadelphia 3, Pennsylvania, for detailed program.

If Your Patient is Going Abroad

Because of the spread of a cholera-like disease in the Far East, all persons should be vaccinated against cholera in advance of a trip there. Persons entering the United States from an infected area will be required to present a certificate of vaccination against cholera.

Pediatric Oncology Course

The Memorial Sloan-Kettering Cancer Center announces that the annual comprehensive three-day course in pediatric oncology for pediatricians and general practitioners will be held in New York on April 25, 26, and 27, 1962.

Current developments and methods in diagnosis, differential diagnosis and management of benign and malignant tumors, Hodgkin's disease, leukemia and reticulo-endothelioses in childhood, are included. The course includes ward rounds, seminars, demonstrations, examinations of children in pediatric, surgical, chemotherapy and radiotherapy clinics.

The class is limited to 15 physicians. The fee is $40.

For more information, write to Department of Pediatrics at Memorial Sloan-Kettering Cancer Center, 444 East 68th Street, New York 21, New York.

List Your Blood Bank Facilities

The New Jersey Blood Bank Commission is compiling a directory of blood bank facilities in our state. This project is endorsed by The Medical Society of New Jersey. The directory will help coordinate blood banking facilities, facilitate exchange of blood and credits, encourage standards of performance and make known these facilities to all who responsibly need them—including Civil Defense workers. Your hospital received a questionnaire last month. Check with your pathologist or hematologist to see if he returned the questionnaire. Any hospital or blood bank facility which, by now, has not received the questionnaire, should write to Essex County Blood Bank at 45 South Grove Street, East Orange, N. J., with a request for a copy.

Psychotherapy Seminar in Philadelphia

A practical, 2-day colloquium on psychotherapy will be held March 15 and 16 at the Temple University Medical Center, Broad and Ontario Streets in Philadelphia. This will include live and filmed treatment sessions showing the "how to do it" aspects of psychotherapy in a practical way. A star-studded faculty has been recruited. For more details, write to Dr. O. Spurgeon English, Department of Psychiatry, Temple University Medical Center, 3403 North Broad Street, Philadelphia 40.

Diabetes and the Lower Extremity

On Wednesday, March 28 the State Department of Health, in cooperation with the New Jersey Chiropodists' Society will offer a symposium on diabetes and the lower extremity. The program includes papers on the management of diabetic foot problems and on occlusive vascular disease in diabetes. The colloquium will start at 1 p.m. and terminate at 5 p.m. at Murdock Hall, Jersey City Medical Center. For detailed program write to Dr. Raymond K. Locke, Engle Street, Englewood, N. J.

Obituaries • • •

DR. GUSTAV FARKAS

While on vacation in Switzerland, Dr. Gustav Farkas died of a heart attack on September 21, 1961. Born in Vienna, in 1899, he was graduated from the University of Vienna with honors in 1924. For the next four years he served on the staff of the Wilhelmine Hospital in Vienna. The subsequent two years were given to special work in tuberculosis at the famous sanitarium in Grimmenstein.

He came to the U.S.A. in 1938 and settled in Passaic as a general practitioner. Dr. Farkas had a particular interest in chest medicine, and was a Fellow of the American College of Chest Physicians. He was active in the affairs of the Passaic County Medical Society. He was on the medical service of both hospitals in Passaic.

DR. MARTIN I. KIRSCHNER

Dr. Martin I. Kirschner of Vernon was stricken with a fatal heart attack on October 2, 1961 at the airport in Port-au-Prince, Haiti, on returning from vacation. Dr. Kirschner was born in 1896. He received his medical degree from the University of Arkansas Medical School in 1925, and had practiced general medicine in Vernon for the past 27 years. He was on the staff of Franklin Hospital and was Vernon school physician and Board of Health supervisor in Vernon Township. Before coming to Vernon he practiced in New York, devoting special attention to neurology.

County Society Reports • • •

Bergen

The regular meeting of the *Bergen County Medical Society* was held December 12, 1961, at Bergen Pines Hospital, Paramus. More than 100 members were present.

The Secretary presented the following applications, which had been recommended by the Membership Committee: John P. Iandoli; Mary Zemaitis; Ralph W. Clemments; Peter Kornfeld and Harry Kosovsky.

The Executive Secretary reported that the Health and Welfare Council of Bergen County were planning a Health and Welfare Show to be held in May 1962. This Society has accepted their invitation to co-sponsor the show. It was agreed that the Society will prepare a major exhibit to illustrate many of the services of this Society to the public. Among these, consideration will be given to emergency medical service; doctor recruitment; school medicine; athletic injury prevention; conservation of vision and educational material. Consideration will also be given to organizing a physician panel for answering questions from the public and visual material such as moving pictures and/or a mechanical "flip viewer."

The Woman's Auxiliary has expressed an interest in joining with the Society in this project and will be asked to do so on a cooperative basis.

Dr. Charles P. Campbell, chairman of the Business Office Committee, announced that the Society Headquarters was now installed in the new building at 215 Union Street, Hackensack. These facilities provide 25 per cent more space at less annual rental than if we had remained at 50 Main Street, and are so designed that two meetings could be carried on concurrently without interference. A private parking lot accommodating 50 cars is located near the building.

The Chair turned the meeting over to Dr. Marshall Driggs, Chairman of the Program Committee, who introduced Miss Jean Wynn, Assistant to the Editor at *Medical Economics*. He then presented the speakers of the evening—Mr. Martin Holbrook, Executive Editor, *The Doctor's Tax Report*, a Prentice Hall publication, who spoke on "The Professional Corporation"; and Mr. Chester L. Chambers of C. L. Chambers Associates, Estate Planning Consultant to the Editorial Staff of *Medical Economics*.

After a very lively and spirited question and answer period, the meeting was adjourned at 11:25 p.m.

CHARLES P. CAMPBELL, M.D.

Reporter

Cumberland

The December meeting of the *Cumberland County Medical Society* was held at the Holly House, Millville, at 9:30 p.m., December 12, 1961, with Harry A. Reinhart, M.D., of Millville, presiding.

Ronald M. Fisher, M.D., of Bridgeton, was unanimously accepted as an Active member.

Benjamin Berkowitz, M.D., of Bridgeton, was appointed chairman of the new committee for the "Chronically Ill and Aged" now in the process of formulation.

Jesse Carl, M.D., of Bridgeton, gave the Maternal Welfare report for Dr. Mary Bacon.

The program for the meeting featured the highlights of the recent AMA meeting in New York City.

There were forty (40) members in attendance.

LEONARD G. SCOTT, M.D.

Reporter

Middlesex

The December meeting of the *Middlesex County Medical Society* was called to order by the president, Dr. Thomas F. McLaughlin.

The speaker of the evening was introduced by Dr. Rudolph Matflerd. He was Mr. Joseph Brophy, attorney for the AMA. Mr. Brophy delivered a most informative address on malpractice suits.

He suggested that a case should be reviewed first by a panel of physicians to determine its defendability. If the case is considered not defendable, it should be settled. If defendable, then the judgment of the panel has usually stood up in court.

Mr. Brophy also suggested that a course on malpractice be given in the last year of medical school.

The following committee reports were presented:

Judicial-Medical Ethics Committee—Dr. B. F. Slobodien, Chairman: Applications presented and voted on for presentation to the Committee on Credentials of the Medical Society for official membership election okay: To Regular membership from two years' Associate membership—Dr. Joseph Pilecki, South River and Dr. Harold Kalman, Edison; to two years' Associate membership—Dr. Norman Hauser, Edison and Dr. Rafael Gordon, New Brunswick.

Dr. Akey, Chairman of the Public Relations Committee, stated that the tetanus immunization campaign will start after January 1, 1962.

It was agreed that we accept the efforts of the public health nurses to consolidate community nursing help.

It was agreed that the Society would pay half of the cost of entertainment at our meeting with the pharmacists.

A letter from the New Jersey Radiologic Society was read suggesting that we refrain from sending ambulatory patients to hospitals for x-rays and laboratory work. The New Jersey Blue Shield has recently added a "rider" which covers these expenses when done in a private office.

A letter from the Hudson County Medical Society was read which stated that the Hudson County Medical Society has passed a resolution objecting to the derogatory statements made by the President of the American College of Surgeons, because of the injury caused to medicine as a whole. The resolution was then accepted by our Society.

EUGENE L. CHILDERS, M.D.

Reporter

Monmouth

The *Monmouth County Medical Society* meeting of September 27, 1961, was held at the Monmouth Shopping Center, Eatontown, with Dr. William D'Elia presiding. William Tompkins, former United States Assistant Attorney General, spoke on "Communist Infiltration, U.S.A." A film titled *Operation Abolition* was shown. Dr. John C. Clark introduced the speaker, who gave an informative talk on the serious nature of communist activities in this country and their threat to our democratic form of government.

Dr. William D'Elia, President, called to order the October 25th meeting of the Society at the Fitkin Memorial Hospital, Neptune. After the business of the Society was concluded there was a panel discussion on "Social-Ethical Problems in Medicine." The panelists were Rabbi Sidney Schulman, Rev. Charles A. Sayre, and the Most Rev. James J. Hagans. Dr. Anthony De Spirito introduced the panelists.

At the Crystal Brook Inn, Eatontown, a dinner meeting of the Society was held on November 29, with an excellent turnout. After a short business meeting and election of new members, Dr. A. De Spirito introduced the evening's speaker, Mr. G. Fuhrman Nettles, Security Analyst for Shearson Hammill Co. Mr. Nettles spoke on stock investments and gave opinions on the general market trends over the next several months. He reviewed space-age stocks specifically and the discussion period which followed was of an interesting and spirited nature.

CYRIL S. ARVANITIS, M.D.

Reporter

Morris

The *Morris County Medical Society* met on November 16, 1961, at the Warner Lambert Laboratories, Morris Plains. Dr. Lawrence Tilney, attending surgeon of the Morristown Memorial Hospital presented a paper on head and neck surgery in the treatment of neoplastic diseases. Several interesting cases were demonstrated to show follow-up results.

Dr. Dexter Blake, president of the county society, held a short business meeting following the speaker, and the meeting was adjourned at 10:30 p.m., followed by collation.

MONROE H. MUFSON, M.D.

Reporter

Book Reviews

Pediatric Anesthesiology. M. Digby Leigh, M.D. and M. Kathleen Belton, M.D. New York, 1960, The Macmillan Company. Ed. 2. Pp. 461 with 203 figures. ($12.00)

This second edition has been completely rewritten and contains much new information. It reviews recent developments which have occurred during the interim in this growing sub-specialty. About half of the text is devoted to the evaluation of the patient with each body system individually considered. Anesthetic agents, technics and equipment are next examined, followed by separate treatment of pre-anesthetic medication and pre-anesthetic care. The final section of the book is devoted to the anesthetic management of surgical procedures involving each of the body systems as well as post-anesthetic care.

This book is written in a manner and with a content that makes it a most useful text for pediatricians, general practitioners and surgeons. It will be valuable, also, to students and specialists in anesthesia. The format is attractive and the bibliography is comprehensive. Many photographs of patients, apparatus and equipment, as well as illustrative diagrams and tables make this a most informative work. Of particular note are the brief but adequate descriptions of the many newborn, infant and childhood conditions which furnish the desired background information for those engaged in this field. All in all this is an authoritative book on a vital subject by learned and experienced authors.

JOSEPH ANTHONY COX, M.D.

The Inspection of Food. By Horace Thornton, D.V.H. Baltimore, The Williams & Wilkins Company, 1960. Ed. 2. Pp. 213, illus. ($3.75)

This handbook of food inspection is not a technical document. It is a good beginning for training lay personnel in some of the background material with respect to the problems faced in the inspection of all types of food. One who has read this book is prepared to continue studying the intricate measures necessary in food, milk, and meat hygiene inspections. In the author's own words he "endeavored when writing this book to present the subject matter in a simple and not too highly scientific manner." He succeeded in this respect.

OSCAR SUSSMAN, D.V.M., M.P.H.

Executives' Health Secrets. By William P. Shepard, M.D. New York, 1961, Bobbs Merrill. Pp. 268. ($4.95)

Dr. Shepard's *Executives' Health Secrets* is a wordy effort to give the American executive practical advise on how to survive in the atomic business world. The worthwhile hints in the book are so well hidden by a mass of seemingly unrelated details that the average reader would understand it little more than he understands the insurance business which Dr. Shepard has served for many years. The only thing that's top secret about *Executives' Health Secrets* is why the book was published at all.

In 252 pages the author rambles from the "A. E. F." to "Yes Men" with such subjects as nurses, bowleggedness, homeopathy, cooking and Charles DeGaulle. The meat, if any, is in the first and last chapters where an attempt is made to give constructive advice. The book is written in a folksy style, misplaced when addressed to top management. It is crammed with anecdotes about grandpaw, intussusception in a four-month-old infant and "dat ol' debbil prostate." In directing his words to the world of the executive (where brevity and clarity are essential) it is regrettable that Dr. Shepard did not follow the first axiom of business: be brief and to the point. I must conclude that the author has lead a life surrounded by insurance forms and not executives.

Impression: Too little meat, too many courses.

ROBERT B. MARIN, M.D.

Thoracic Diseases. By Emil H. Rubin, M.D. and Morris Rubin, M.D., in association with George C. Leiner, M.D. and Doris J. W. Escher, M.D. Philadelphia, 1961, Saunders. Pp. 968, illus. ($25.00)

This comprehensive textbook opens a new frontier for our understanding and recognition of thoracic diseases and their treatment. The approach to the cardiopulmonary relationships with circulatory and respiratory features is unique.

The seriousness of respiratory diseases in the young with the sequelae later seen in the older age groups is stressed. Emphasis is rightfully placed on the acute and chronic chest diseases such as the common cold, pneumonia, asthma, bronchitis, bronchiectasis, emphysema and cor pulmonale. Adequate space is given to dust-borne diseases, occupational hazards, fungous infections, pulmonary manifestations of generalized diseases and

collagen diseases. Even bizarre diseases are described.

Many chapters are devoted to such threatening problems as intrathoracic neoplasms, especially bronchogenic carcinoma. Great stress is placed on pulmonary tuberculosis which remains one of our most formidable diseases.

Of great importance in this book is the description of pulmonary emergencies, diseases affecting the pleurae, subjacent structures, diseases of the mediastinum, diaphragm and injuries to the heart, great vessels and mediastinum.

The final two chapters on the principles of diagnosis are uniquely placed. This is understandable, for as one carefully reads this text, he realizes the importance of a meticulous history, physical examination, x-ray and laboratory aids to arrive at an intelligent diagnosis and proper treatment. The philosophy expressed in the last few pages on the changing features in medicine, makes one proud to strive to be a good physician and a humanitarian.

The book is profusely illustrated by case histories, excellent x-ray reproductions, tables, charts and histologic as well as gross specimens. A detailed bibliography is given after each chapter.

I unreservedly recommend this new textbook to internists, pediatricians and medical students. It should be available as a reference for intern and resident teaching programs. Some of its sections are of interest to obstetricians.

MAX GROSS, M.D.

The Gentle Legions. By Richard Carter. New York, 1961. Doubleday. Pp. 335. ($4.50)

In his book *The Doctor Business*, Mr. Carter really gave doctors the business. He is much gentler in this volume which deals with the large national voluntary health organizations like the Red Cross, the National Foundation and the others. He is not so gentle with local community chests and welfare federations, however. He considers United Appeals and similar federated money-raising units to be inefficient, lacking in sound psychological appeal, and unable to help develop research. Mr. Carter has enormous respect for the large, nationally operated, voluntary health organizations. He considers them one by one, giving the history of each, and listing their accomplishments. The National Association for Mental Health he feels is "beyond its depth" and that this organization "does not have the stomach" for what has to be done in the mental health field. With this sole exception, all the large voluntary health organizations get an accolade.

There is an excellent chapter on the motivation of volunteers, and another on the pros and cons of having organizations dominated by the victims of the disease concerned. Mr. Carter realizes the anarchy that prevails with overlapping and competing organizations, but he feels that they all accomplish so much good that this is a small price to pay. He includes a stimulating discussion of the role of the professional planner, and his relationship with the volunteers. Also reviewed is an analysis of fund-raising technics. The book is interesting, and will give physicians the background that they ought to have (but usually don't have) in discussing the role of voluntary health organizations on the American scene.

HENRY A. DAVIDSON, M.D.

Epidemic. By Frank G. Slaughter, M.D. Garden City, 1961. Doubleday. Pp. 287. ($3.95)

The author is a doctor and the name of the book is *Epidemic*. But this is not a public health text. It is a novel: a melange of international intrigue and a yarn about how New York might conquer an epidemic of bubonic plague. It is counterpointed by a corny love story that belongs in soap opera. (Will the beautiful nurse marry the rich young surgeon or will she go to the jungle of Laos and share the rugged life of the dedicated epidemiologist?) Dr. Slaughter leans heavily on surgical details to fascinate the lay reader. The thread of the story is, in its way, rather exciting. The narrative shows how bubonic plague could get a foothold in New York, and how it could be handled. The pace is swift, and the mounting tension ends with an old fashioned gun-toting chase amid the tombstones of a Queens cemetery. Puerto Rican gang fighters, international spies, and eccentric millionaires complete the cast.

VICTOR HUBERMAN, M.D.

Outline of Pathology. J. H. Manhold, M.D. and T. E. Bolden, M.D. Saunders, 1960. Pp. 340 (no illustrations). ($4.75)

This volume is exactly what the title states: "an Outline." The difficult task of outlining "pathology" completely is done as well as possible. Organization of material is good and the book may find a place as a study aid in addition to a standard pathology textbook. The lack of explanatory text is unfortunate as it leaves the student with no understanding of the mechanisms of disease processes. As a vehicle for rapid review before an examination, the book will be embraced by students and by those preparing for State Board and E.C.F.M.G. examinations. It is probable, though, that little can be retained by the student from study of an outline.

While the classification of diseases is good, on the whole, there is some straying from the path usually trod by standard texts which form the bases of study in pathology. For example, it is unusual to find congenital defects and neoplasms combined under disorders of growth and at the

same time to separate headings, with no apparent relation, for inflammatory diseases, granulomatous diseases, and parasitic diseases. It would also be confusing to a neophyte to consider bacterial diseases as inflammatory and viral diseases as parasitic. It is debatable, too, whether Laennec's and biliary cirrhosis should be included in inflammatory diseases. It is certainly wrong to include cardiac cirrhosis under the same heading.

Despite these minor criticisms, which will probably be rectified in subsequent editions, the volume will find a place in the student's pocket. The type is easy on the eyes and the liberal use of heavy print will be appreciated. The authors have attempted the impossible and have partly succeeded.

PAUL STEINLAUF, M.D.

Fundamentals of Nerve Blocking. Vincent J. Collins, M.D. Philadelphia, 1960, Lea & Febiger. Pp. 354 with 144 figures. ($9.50)

Regional anesthesia was first developed in the United States by Dr. William Stewart Halstead in 1884. It was then advanced by Dr. Gaston Labat, who devised many of its procedures. Its widespread clinical application and extension to include therapeutic nerve blocking was due to the untiring efforts of Dr. Emory Andrew Rovenstine, who assisted the author, Dr. Vincent J. Collins, in the preparation of this book. Each of these four pioneers in nerve blocking was associated with Bellevue Hospital in New York. Therefore, it is quite appropriate that this publication is written by an anesthesiologist on the staff of that hospital.

Dr. Collins is to be commended for his clear, concise, authoritative text which presents the fundamentals in a logical, easily comprehended and up-to-date manner. All phases of nerve blocking are covered. In addition to the historical development, principles governing its use and the pharmacology of agents, attention is paid to the underlying neurophysiology of sensation and pain mechanisms. After consideration of a classification of diseases amenable to therapeutic and diagnostic nerve blocking, the author discusses each in detail. Finally, the various regional technics are detailed anatomically with abundant excellent figures accompanying and illustrating the descriptions.

While the text is written by an anesthesiologist about a subject pertinent to that specialty, it represents a most instructive and reliable addition to the library of any physician interested in pain syndromes and this modality of diagnosis and therapy.

JOSEPH ANTHONY COX, M.D.

Thoracic Surgery Before the 20th Century. By Lew A. Hochberg, M.D. New York 1960. Vantage Press. Pp. 858. ($15.00)

In this period of rapid advances in thoracic surgery (especially in cardiovascular disease) consideration should be given to the seemingly slow and difficult progress made in the past. Hochberg has provided a ready access to the story of the development of thoracic surgery from the time of the Edwin Smith papyrus (1600-3000 B.C.) through the nineteenth century. His collation of references has entailed a long and careful labor. The author is to be congratulated on so complete a volume.

This is not a book that can be read through in continuous sittings. Because of extensive quotations from the early writers (which are the unique merit of this work) reading is somewhat difficult. The book should be kept at hand and read from time to time until finished. The work is embellished with 155 illustrations from earlier writings.

Hochberg has opened the door to our understanding of the development of an important surgical specialty. The opportunity to acquire knowledge of the history of thoracic surgery should not be neglected by the specialists of this day.

GEORGE N. J. SOMMER, JR., M.D.

Current Therapy—1961. Edited by H. F. Conn, M.D. Philadelphia, 1961. Saunders. Pp. 806. ($12.50)

Modern technology, scientific progress and current promotional methods have made therapy a jungle of contradictory—sometimes screaming—claims. The practitioner needs help to hack his way through that jungle—and here books like *Current Therapy* constitute a veritable rescue party. The special feature of this text is that the material is presented as "The Method of Dr—." The contributor takes the responsibility for the regimen, and indicates that it is the technic that, in his hands, has given best results.

The book is divided into the conventional chapters: infectious diseases, the respiratory system, the cardiovascular system and so on. Therapy is not limited to drugs and pharmaceuticals. The book includes an exceptionally valuable compendium on poisons—listing poison control centers, and even giving a list of common commercial products (alphabetically arrayed from Absorbine, Jr., through Lestoil and Simoniz to Windex) with the active ingredients identified. In the end papers are valuable tabulations of laboratory norms. All together, a one-man medical practice book!

ULYSSES M. FRANK, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

FEBRUARY, 1962 • VOL. XXXV, No. 2

THE EMERGING PATTERN OF URBAN HISTOPLASMOSIS

An epidemic of the fungous disease occurred in Mexico, Missouri, among a group of boys who had helped clear a large city park. Soil samples from the park, a favorite roosting place for starlings, yielded positive cultures for Histoplasma capsulatum.

Urban children, because of their more localized environment and less frequent exposure, appear to be more suitable subjects than rural children for studies of the acquisition of infection with *Histoplasma capsulatum*. Three sources of infection among urban children have been reported: visits to farms or prior rural residence, exposure in urban structures contaminated with bird droppings, and importation of contaminated farm soil or manure as fertilizer.

In the present paper we wish to call attention to a fourth source of infection among urban children, namely, infection in wooded, open park areas contaminated by bird droppings. This mode of infection is illustrated by the report of an epidemic.

THE EPIDEMIC

Mexico is a city of 15,000 people in east central Missouri. During the second week in April, 1959, similar illnesses characterized by chills, high fever, and cough developed in four boys in Mexico. All four had x-ray films of the chest taken at the local hospital, and two were admitted there. The clinical features and x-ray findings in these four cases led the hospital radiologist to suspect histoplasmosis. Positive skin and serologic tests later confirmed the diagnosis.

An interview with these boys revealed that they were all Boy Scouts and members of the same troop. Furthermore, their only close association was related to scouting activities. All four had onsets of illness within twelve to fourteen days after March 28, 1959. On that day a group of 64 Scouts from the four Mexico troops had worked together clearing a large city park.

Since it was probable that a large proportion of the Scouts in Mexico had been exposed to the infection, arrangements were made through the organization for further investigations. An epidemiologic questionnaire was completed by 113 boys, but not all were willing to have skin and serologic tests and x-ray examination.

TESTS PERFORMED

The standard used in skin testing was of a potency equivalent to standard histoplasmin. Two complement-fixation tests were performed, histoplasmin being used as antigen in one and whole-yeast phase organisms in the other. X-ray films, 14 by 17 inches, were evaluated by physicians experienced in the interpretation of chest films.

Soil samples were collected on several occa-

M. L. Furcolow, M.D.; F. E. Tosh, M.D.; H. W. Larsh, Ph.D.; H. J. Lynch, Jr., M.D.; and G. Shaw, M.D., *The New England Journal of Medicine*, June 15, 1961.

sions from the park suspected as the source and cultured for *H. capsulatum*.

The site of the epidemic was a part of 11 acres on which a large, plantation-type home, built before the Civil War, is located. The house had fallen into disrepair and the grounds converted into pasture for livestock. The grounds had been completely untended for 15 or 20 years and had become heavily overgrown with brush and trees. The city of Mexico had grown around the property so that the park now lies near the center of the city.

In December, 1958, when the city began clearing the property, it was described as a jungle, with dense underbrush and vines among large trees. Leaves and debris were at least several inches deep. Since about 1950 the park had been a favorite roosting place for starlings. By the summer of 1955 thousands of these birds inhabited the park and their droppings almost completely covered the ground. Because of the noise of the birds and the disagreeable odor, the local residents had undertaken eradication measures. Despite a marked decrease in the bird population, at the time of the epidemic there was still evidence of considerable bird droppings.

HISTOPLASMIN RESULTS

Of 64 boys who worked in the park, 62, or 97 per cent, had positive histoplasmin tests, 36 of 60, or 60 per cent, had positive complement-fixation tests for histoplasmosis, and 28 of 60, or 47 per cent, had active lesions on x-ray. Of a group of boys who had not worked in the park only 41 per cent had positive skin tests, 25 per cent had positive complement-fixation tests, and 25 per cent had active lesions on x-ray films. It appears that practically all the exposed susceptible boys became infected. It is not surprising to find a number with evidence of *H. capsulatum* infection even though they did not work on the property because Mexico lies within a highly endemic area. Furthermore, the central location of the park favored casual visits and exposures.

Only 10 of the boys who worked in the park gave a history of clinical illness. Nine of these had positive histoplasmin skin tests and serologic and x-ray findings. In the other boy, only the skin test was performed and it was positive. In five of the 10 boys a moderately severe illness developed, lasting from one to six weeks, with symptoms of chills, fever, cough, malaise, and chest discomfort. The other five reported symptoms of a mild upper-respiratory tract infection lasting a few days.

Sixty-two per cent of all soil samples collected from this property were positive for *H. capsulatum* by culture, an unusually high yield. There is little doubt that the fungus was flourishing abundantly throughout a large portion of the park site.

The question arose of whether the frequency of isolations from the park represented an unusual prevalence of the fungus or merely reflected a high prevalence throughout the entire area. Thus, soil samples were collected from six selected sites within a radius of three miles from the city of Mexico and in the city itself. Only one of the soil specimens was positive for *H. capsulatum*. It is clear, therefore, that the frequency of isolations from the park was unique and not in any way typical of similar sites in the same areas.

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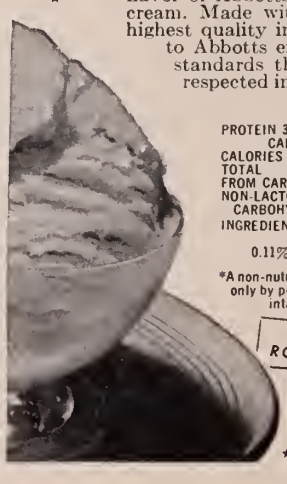
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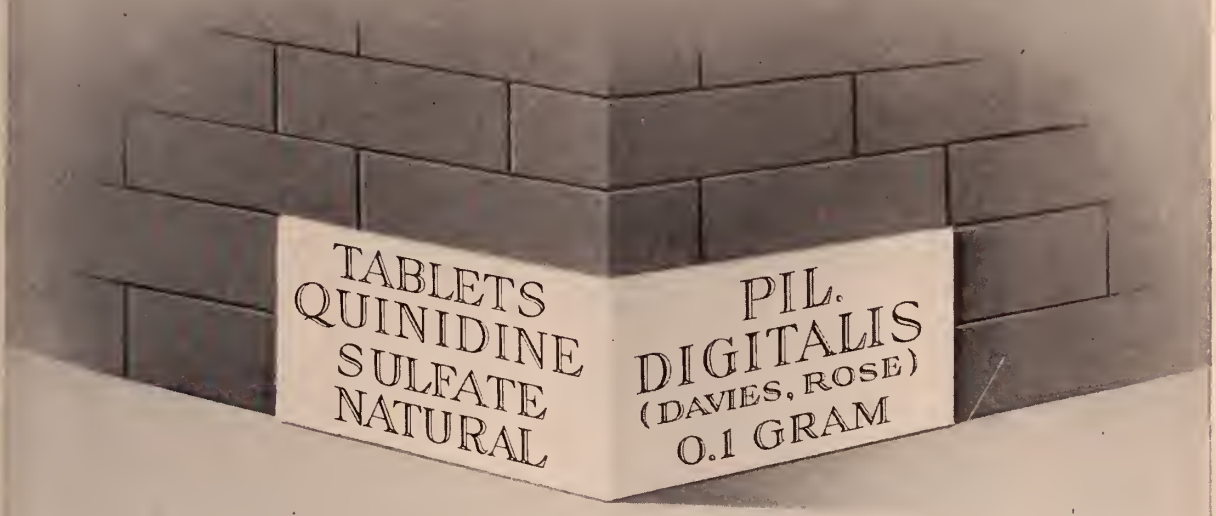
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Q What is real estate syndication?

A It is a group effort which permits the small investor to purchase income producing real estate that formerly was beyond his financial reach.

Q What are current yields and how are they paid?

A Yields currently range from 9 to 15% annually, paid on a monthly basis.

Q How can syndication benefit a doctor?

A Participation in syndication is an ideal way to convert ordinary income into long term capital gains, thus lessening the investor's tax burden.

Q Give a concrete example of how ordinary income converts to long term capital gains.

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BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
BLOOMFIELD	Jay W. Clark, Pharmacist, 170 Broad St., Belleville Ave.	PIlgrim 3-4150
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	PO. 8-0070
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EATONTOWN	Town Pharmacy, 17 Main St.	LIberty 2-0547
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
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FLEMINGTON	James L. Ryan, R.P., 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
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GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
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JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Fred T. Fiore, 14 Rose Ave.	DElaware 3-7509
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
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MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
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ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
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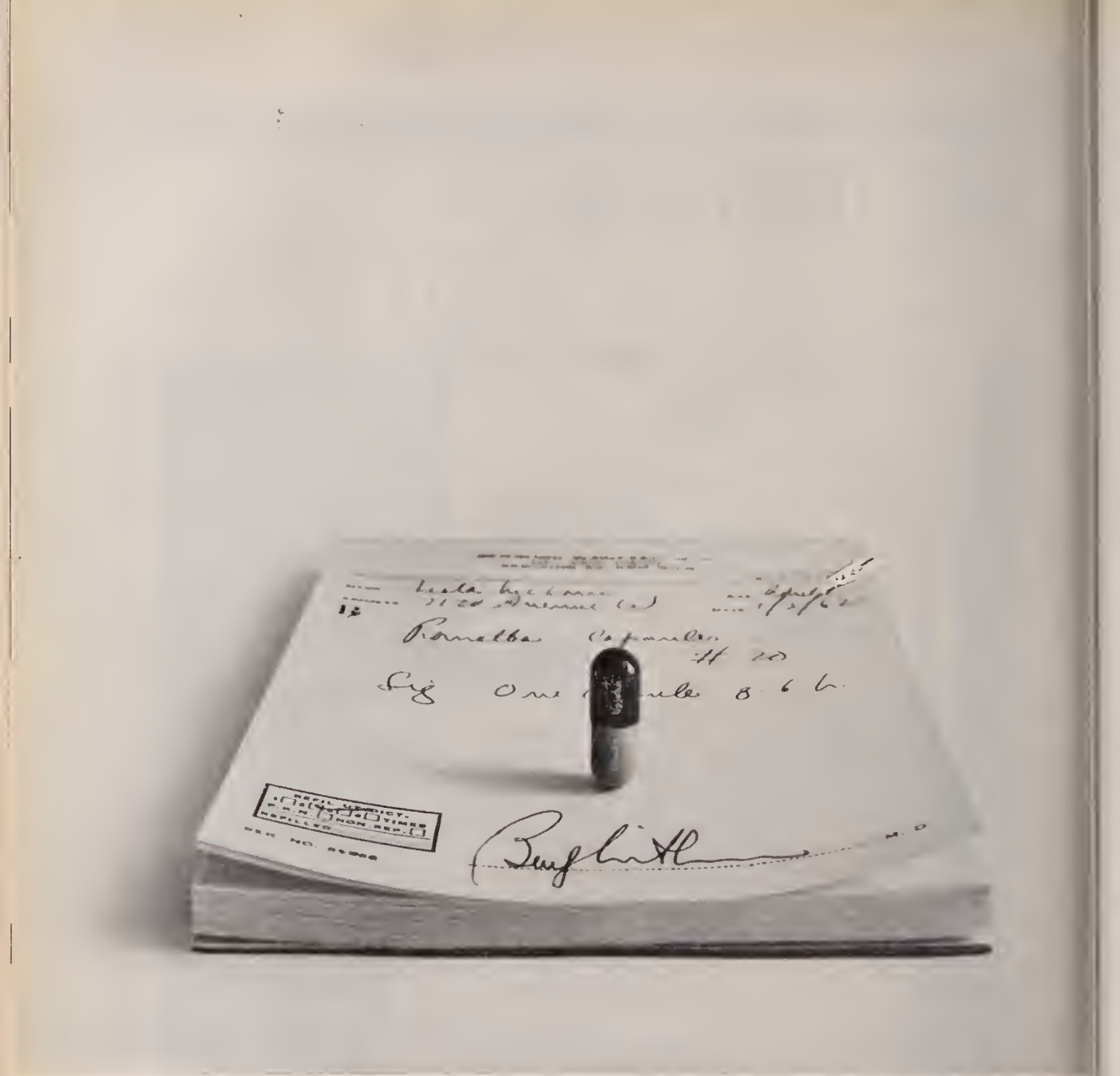
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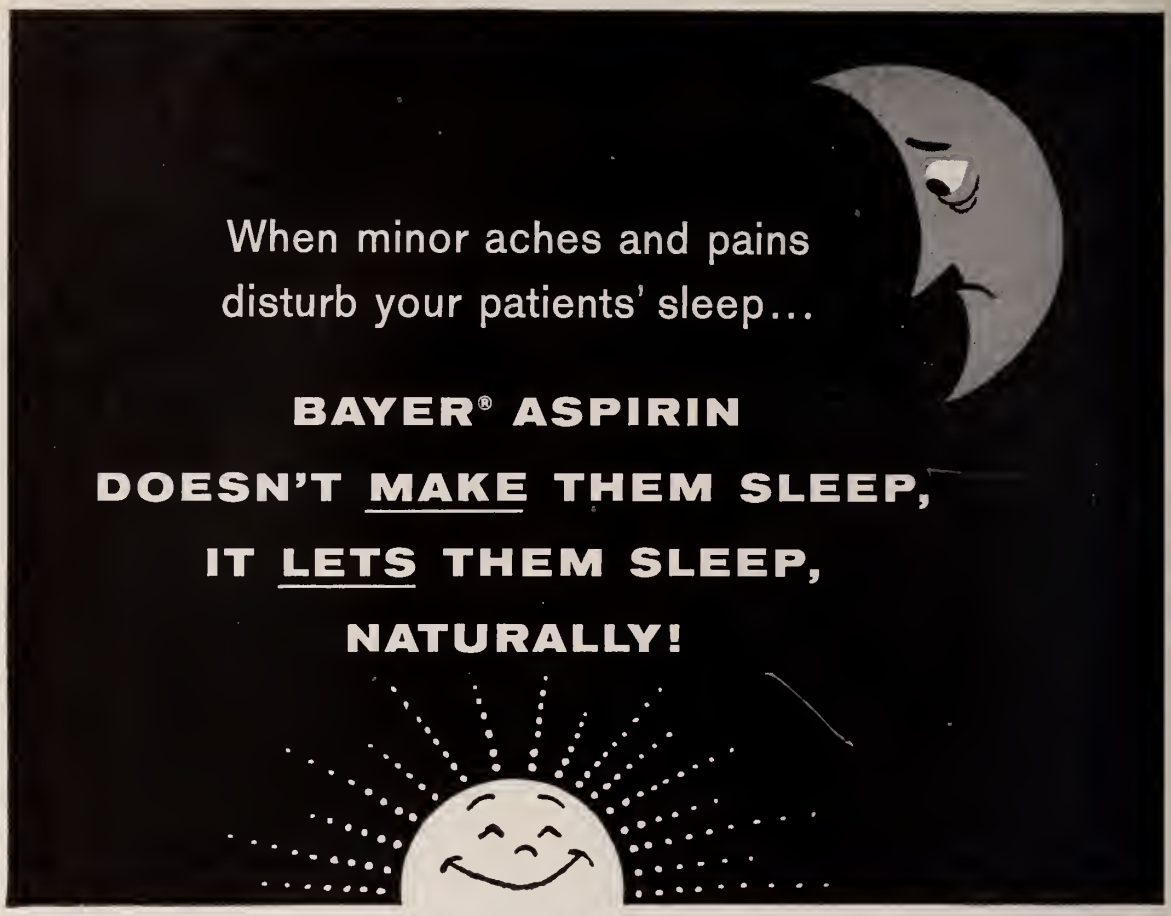


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AND WITH BAYER ASPIRIN,
THERE'S NO
"SEDATIVE HANGOVER."

There are, of course, a great many instances of sleeplessness in which the patient should be directed to take a sedative to induce sleep.

But there are also many instances in which sleeplessness is caused by nothing more serious than minor aches and pains which can easily be relieved by one or two tablets of Bayer Aspirin. With physical discomforts gone, sleep comes naturally.

And when Bayer Aspirin is used as a sleeping aid, patients never suffer the "sedative hangover" which so often follows an induced sleep.

So remember, when minor aches and pains disturb your patients' sleep, Bayer Aspirin doesn't make them sleep; it lets them sleep, naturally, with no "sedative hangover."





Even if you prescribed a year's supply



the last Optilets® Filmtab® would still be good

Actually, doctor, labeled potency will last a much longer time. While we would never recommend by-the-year dosage of a therapeutic nutritional, this does illustrate the unusual stability of Optilets.

The reason, of course, is Filmtab coating. Unlike previous sugar coatings, no water is needed for application. This virtually eliminates chances of moisture degradation.

Greater stability, however, is just one of Optilets advantages. Without sugar's bulk, we can make tablets up to 30% smaller in size. Coatings are less brittle, and tablets less apt to chip or break. As Filmtab coatings are no more than paper-thin, nutrients are more readily available. Yet, patients are protected from vitamin odors and after-tastes.

While stability is important and easy administration an advantage, ingredients are, of course, the main criteria for any nutritional. Please check the Optilets formulas, doctor. We think you'll find them a good choice for your patients.

ABBOTT LABORATORIES NORTH CHICAGO, ILLINOIS

Optilets

Each Filmtab represents:

Vitamin A	7.5 mg. (25,000 units)
Vitamin D	25 mcg. (1000 units)
Thiamine Hydrochloride	10 mg.
Riboflavin	5 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
Cobalamin (Vitamin B_{12})	6 mcg.
Calcium Pantothenate	20 mg.
Ascorbic Acid	200 mg.

Optilets-M®

Each Filmtab represents all the vitamins of Optilets plus the following:

Iron (as sulfate)	10 mg.
Copper (as sulfate)	1 mg.
Iodine (as calcium iodate)	0.15 mg.
Cobalt (as sulfate)	0.1 mg.
Manganese (as sulfate)	1 mg.
Magnesium (as oxide)	5 mg.
Zinc (as sulfate)	1.5 mg.
Molybdenum (as sodium molybdate)	0.2 mg.



...you can bet they're not from Abbott

itamin products generally taste fine going down, but egurgitative effects may often be downright unpleasant. While this seems like a minor problem, bad aftertaste an discourage patients from continuing needed medi-ation ■ Filmtab coatings guard against this possibility. itamin repeat is brought to a minimum. Unpleasant lors and aftertastes are effectively sealed inside the ilmtab. Tablets are also *much* easier to take as they can be up to 30% smaller in size. Bulky sugar coatings have been eliminated and breakage and cracking are less likely ■ As for stability—it's enhanced! No water is used in Abbott's Filmtab coating process. Chances of moisture degradation are virtually eliminated ■ When you recommend Abbott vitamins, Doctor, patients get the potency they pay for—today, tomorrow, a year from now.

ABBOTT

Imtab® vitamins by Abbott: Dayalets® / Dayalets-M® / Optilets / Optilets-M® / Sur-Bex® with C / Surbex T®

FILMTAB – FILM-SEALED TABLETS, ABBOTT. 202076

In intestinal "grippe"

prompt 4 way check of diarrhea

- Curbs excessive peristalsis
- Adsorbs toxins and gases
- Soothes inflamed mucosa
- Provides intestinal antisepsis



POMALIN

TRADEMARK

Liquid

EFFECTIVE ANTIDIARRHEAL

FORMULA: *Each 15 cc. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. paregoric)	

DOSAGE: **Adults:** Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

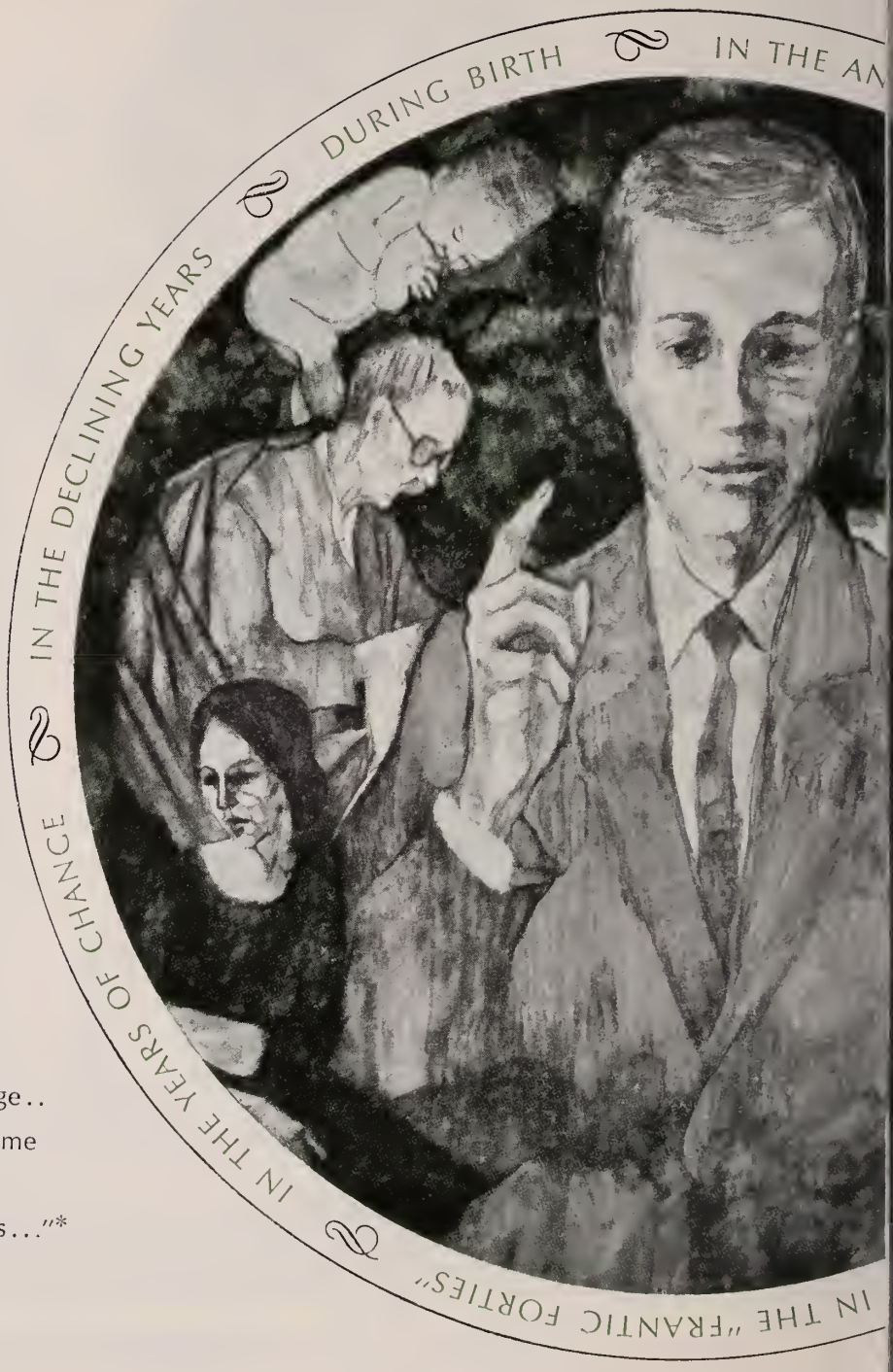
Children: ½ teaspoon (= 2.5 cc.) per 15 lb. of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

Winthrop LABORATORIES
New York 18, N. Y.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.



SUPPLIED: *Bottles of 16 fl. oz. (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.



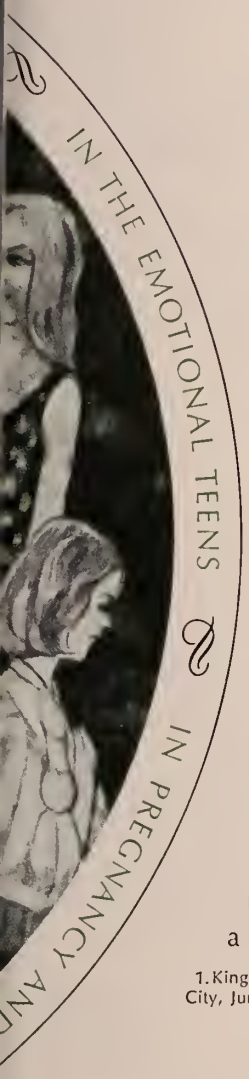
"All the world's a stage..
And one man in his time
plays many parts,
His acts being seven ages..."*

*As You Like It, Act II, Sc. 7

through all seven ages of man

VISTARIL®

effective anxiety control with a wide margin of safety



in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

In each of these areas, VISTARIL is often effective alone or as an adjunct to other therapy. For example, in his series of 67 patients, King[1] found that 62 showed remission of anxiety, tension, nervousness and insomnia, as well as alleviation of symptoms associated with various functional and psychophysiological disturbances. He concludes that VISTARIL is well suited for use in the practice of internal medicine.

In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

VISTARIL® CAPSULES AND ORAL SUSPENSION
HYDROXYZINE PAMOATE

VISTARIL® PARENTERAL SOLUTION
HYDROXYZINE HYDROCHLORIDE

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Division, Chas. Pfizer & Co., Inc.
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See "IN BRIEF" on the next page.

IN BRIEF VISTARIL®

VISTARIL, hydroxyzine pamoate (oral) and hydroxyzine hydrochloride (parenteral solution), is a calming agent unrelated chemically to phenothiazine, reserpine, and meprobamate.

VISTARIL acts rapidly in the symptomatic treatment of a variety of neuroses and other emotional disturbances manifested by anxiety, apprehension, or fear—whether occurring alone or complicating a physical illness. The versatility of VISTARIL in clinical indications is matched by wide patient range and a complete complement of dosage forms. The calmative effect of VISTARIL does not usually impair discrimination. No toxicity has been reported with the use of VISTARIL at the recommended dosage, and it has a remarkable record of freedom from adverse reactions.

INDICATIONS: VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

More detailed professional information available on request.

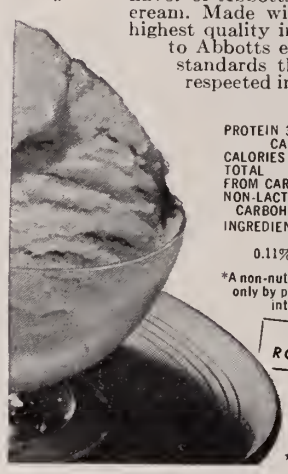
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Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry.



COMPOSITION
PROTEIN 3.52% MILK FAT 10.52%
CARBOHYDRATES 21.35%

CALORIES PER OUNCE	AVOIR.	FLUID
TOTAL	55.02	33.31
FROM CARBOHYDRATES	24.21	14.66
NON-LACTOSE CARBOHYDRATES	18.03	10.92

INGREDIENTS: CREAM, MILK, SORBITOL, STABILIZER AND 0.11% CYCLAMATE CALCIUM*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

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Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

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(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

Acts within minutes—KOAGAMIN, unlike other hemostatic agents, acts *quickly* in *minimal* dosages. Working on the late phases of the clotting mechanism, KOAGAMIN does not require massive and prolonged pre- or postoperative dosages to control capillary and venous bleeding.

Acts with predictable safety—In 20 years of clinical use, no toxic or side actions have been reported with KOAGAMIN. Bleeding is arrested without danger of thrombosis, and because KOAGAMIN contains no protein or alkaloid, it can be administered without danger of sensitization or untoward reactions.

Acts effectively in a broad range of indications—Because of its *unparalleled safety* and *outstanding effectiveness*, KOAGAMIN has been successfully employed in...hemorrhagic diseases, abnormal bleeding, blood disorders, surgical cases and trauma.

KOAGAMIN, an aqueous solution of oxalic (5 mg. per cc.) and malonic (2.5 mg. per cc.) acids for parenteral use, is supplied in 10-cc. diaphragm-stoppered vials.

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KOAGAMIN®

(parenteral hemostat)

controls bleeding with minimal dosage and maximum safety

10360



for more satisfactory relief of anxiety-aggravated pain

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- More satisfactory than "the usual analgesic compounds" for relieving pain and anxiety.[1]
- More effective than a standard A.P.C. preparation for relief of moderate to severe pain.[2]

Each PHENAPHEN *capsule contains:*

Acetylsalicylic acid (2½ gr.)	162 mg.
Phenacetin (3 gr.)	194 mg.
Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Also available:

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PHENAPHEN with CODEINE PHOSPHATE 1 GR. (64.8 mg.) Phenaphen No. 4

Bottles of 100 and 500 capsules.

1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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MEDICAL-SURGICAL PLAN of New Jersey this month observes the 20th Anniversary of its founding by The Medical Society of New Jersey.

On behalf of the Plan's more than 2,000,000 members, Blue Shield extends to its Participating Physicians, whose loyal support has made possible our first two decades of service and progress, *thanks* —

- For making a humanitarian concept a working reality
- For easing the financial burdens imposed by serious illness and accident on those least able to bear them unassisted
- For willingness to accept personal sacrifices in order to benefit the community
- For contributing to maintaining the dignity and self-respect of thousands who otherwise might be forced to seek charitable medical assistance
- For realization that only such a cooperative program of the medical profession and the community can provide necessary health care protection in the atmosphere of free American enterprise
- For patience and understanding when the complex machinery of the Plan sometimes must move slower than they would like
- For continuing loyalty to the Blue Shield philosophy and its implementation

With the cooperation and support of its Participating Physicians, New Jersey Blue Shield in the years ahead will continue to provide the means by which the medical profession makes available the finest of health care at the most reasonable cost.



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Applications considered at all times.*

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*New members have special privileges during first few months of membership; ask for specific details if you were recently elected and have not received notifications from us. All applications subject to company rules and regulations for acceptance of risks.

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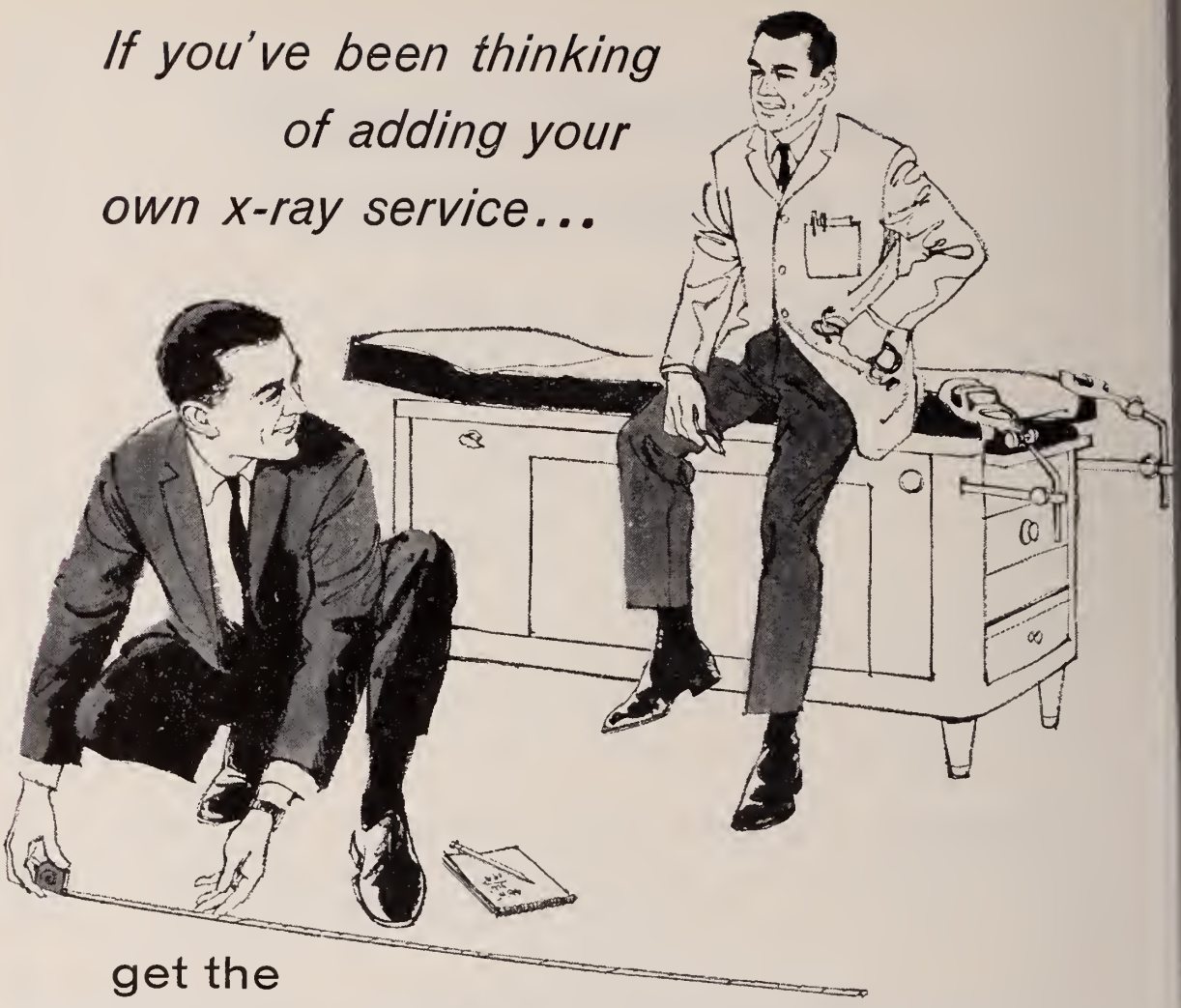
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For gallbladder patients Entozyme may provide significant relief from the discomforts of fat-induced indigestion. Just six Entozyme tablets (the usual daily dose) digest sixty grams of fat—or more. That's as much as 50 to 90% of the normal daily intake of average adults.

The reason for Entozyme's fat-digestion potency is that each tablet contains 150 mg. of Bile Salts and 300 mg. of Pancreatin, N.F. (in an enteric coating). Bile Salts stimulate the flow of bile and enhance the lipolytic activity of both Entozyme's Pancreatin and the patient's own lipase. Together Bile Salts and Pancreatin greatly aid the emulsification and transport of fat.

Entozyme also contains Pepsin, N.F., 250 mg., which facilitates the breakdown of protein.

A. H. Robins Company, Inc., Richmond 20, Virginia

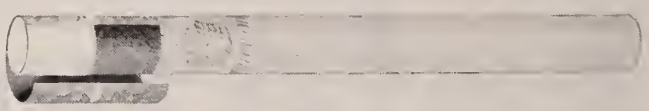
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In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

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Vitamin B_1 (Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Niacinamide	100 mg
Vitamin C (Ascorbic Acid)	300 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily or as directed by physician, for the treatmen of vitamin deficiencies.

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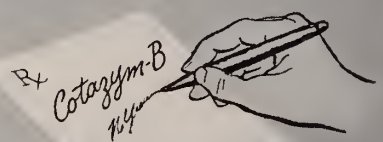
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– PLUS BILE SALTS TO AID IN DIGESTION OF FAT, AND CELLULASE TO AID IN DIGESTION OF FIBROUS VEGETABLES



COTAZYM-B is a new comprehensive digestant containing bile salts, cellulase and *lipancreatin* for supplementing deficient digestive secretions and helping to restore more normal digestive processes. *Lipancreatin* —"the most potent pancreatic extract available"[3]—is a concentrated pancreatic enzyme preparation developed by Organon.[4] It has been clinically proven to be an effective agent for treating digestive disorders of enzymatic origin.[1,4,5,6,7,8] COTAZYM-B is indicated for the symptomatic relief of dyspeptic or functional digestive disturbances characterized by bloating, belching, flatulence and upper abdominal discomfort.

Dosage: 1 or 2 tablets with water just before each meal.

Organon

REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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Lipancreatin Bile Salts Cellulase



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THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / expectorant
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■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains: Hycodan®

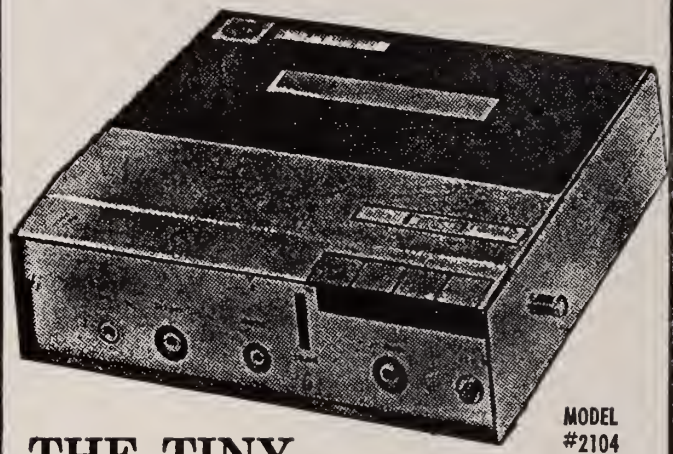
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.	6.5 mg.
Homatropine Methylbromide	1.5 mg.	
Pyrilamine Maleate		12.5 mg.
Phenylephrine Hydrochloride		10 mg.
Ammonium Chloride		60 mg.
Sodium Citrate		85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law allows oral prescription.

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FARMINGDALE	Burke Rexall Drugs, Main St. opp. Bank & Post Office	WEbster 8-9051
FLEMINGTON	James L. Ryan, R.P., 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
FREEHOLD	Wood's Pharmacy, 2 E. Main St., cor. South	FReehold 8-0668
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	DElaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Fred T. Fiore, 14 Rose Ave.	DElaware 3-7509
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office	COlfax 4-0904
LAKEWOOD	Burke Rexall Drugs, Cor. 4th and Monmouth	FOxcroft 3-7133
LITTLE FERRY	Copello's Drug Store, 229 Main St.	DIamond 2-5534
MILLTOWN	Family Prescriptions, Inc., 122 North Main St.	MIlltown 8-1321
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BElmont 5-0088
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-3800
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	G. Maggio's Prescription Pharmacy, 136 Fleming Ave.	MItchell 2-8915
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	7th Avenue Pharmacy, Inc., 71 - 7th Ave.	HUmboldt 3-7676
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NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
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(Continued on following page)

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(Continued from preceding page)

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PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PENNSAUKEN	Thor's Rexall Drugs, 4919 Westfield Ave.	NOrmandy 2-0848
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Bell Drug Store of Rahway, Inc., 1552 Irving St.	FUlton 1-2000
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TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
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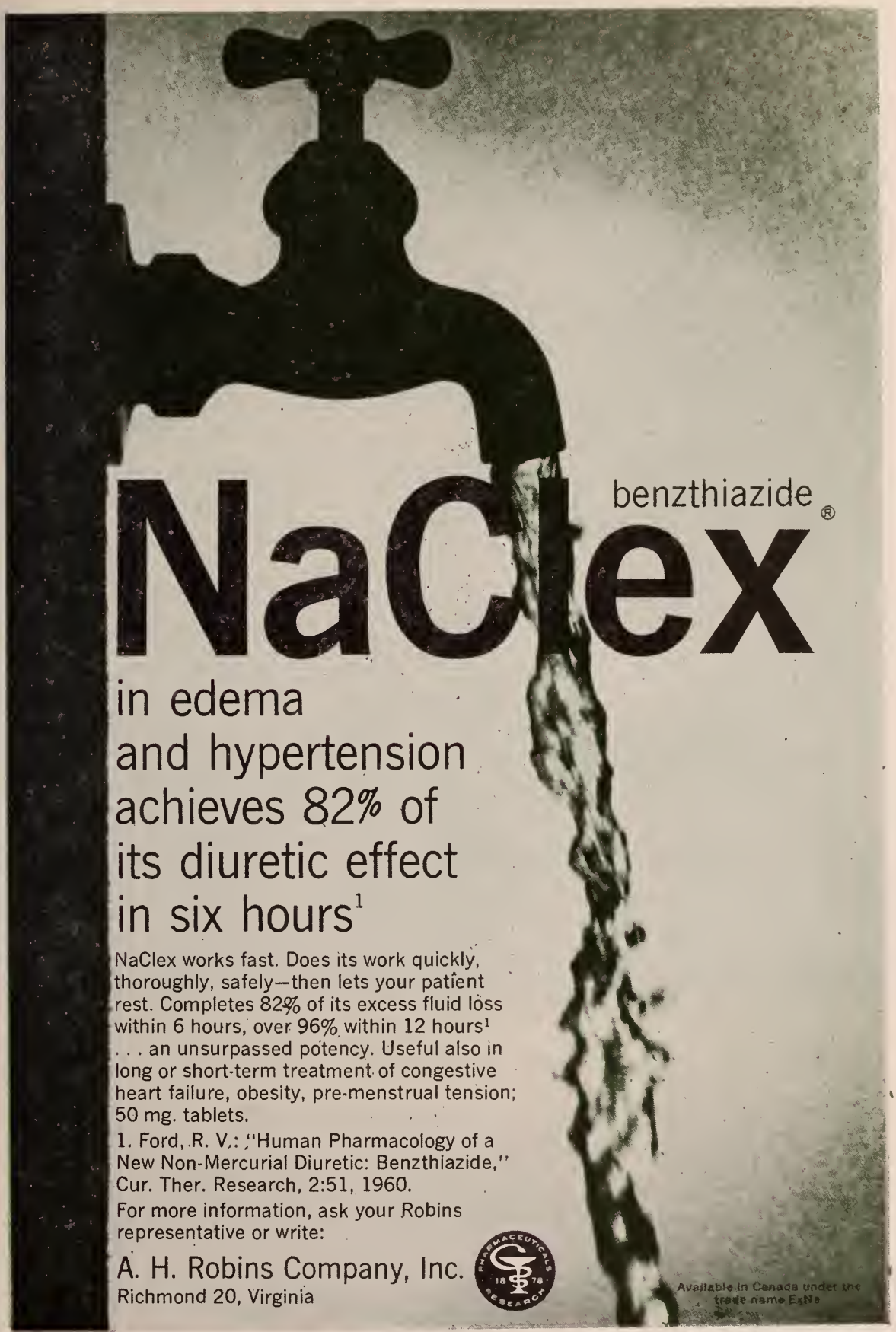
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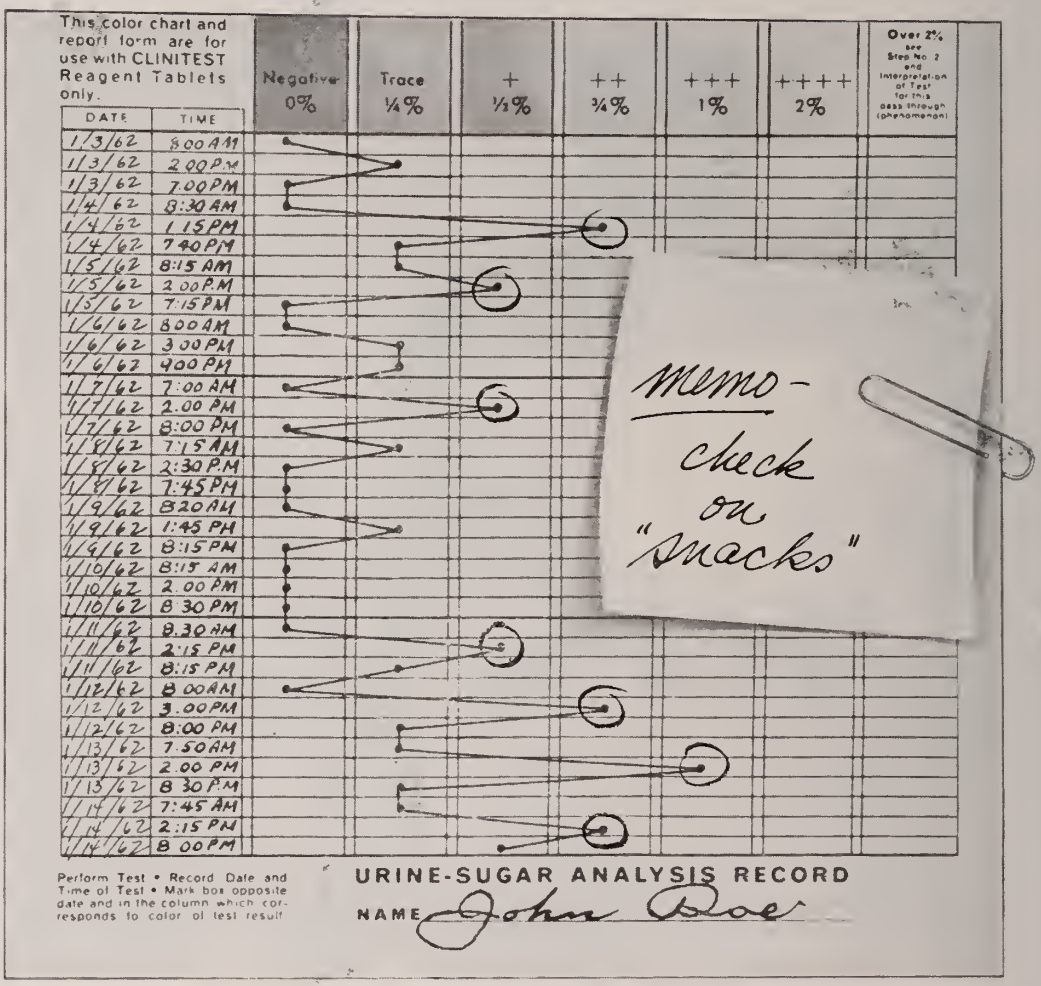
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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.
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fluid loss in patients with congestive heart failure. It is at least as effective as the parenteral mercurials in initiating diuretic therapy. The safety, continuing effectiveness and potency of hydrochlorothiazide* render it a valuable agent for maintenance therapy to keep patients in an edema-free state. Many are unable to, or will not follow a strict salt-free diet; it is important to note that salt restriction may be liberalized. Mercurials may be added to a hydrochlorothiazide regimen, if necessary.[9-14]

The present investigation was undertaken to appraise the effects of hydrochlorothiazide* and hydrochlorothiazide* plus a mercurial in the treatment of toxemia of pregnancy and congestive heart failure following arteriosclerotic cardiovascular or hypertensive cardiovascular diseases.

MATERIALS AND METHODS

FIFTY-SIX hospitalized patients were divided into three groups.

Group I. This consisted of 21 patients (age range 4 to 87) with congestive heart failure treated with hydrochlorothiazide* alone.

Group II. This consisted of ten patients (age range 40 to 79) with congestive heart failure who were treated with a mercurial plus hydrochlorothiazide.*

Group III. This consisted of 25 females with toxemia of pregnancy (age range 14 to 38) who received hydrochlorothiazide.*

When a patient required additional medication, these were administered. Thus, we used sedatives, digitalis preparations, xanthines and antihypertensive agents.

Average daily dose of hydrochlorothiazide* was individualized to patient requirements. The Group I dosage varied from 50 to 300 milligrams; Group II from 100 to 200 milligrams; Group III dosage was 100 milligrams. The mercurial diuretic administered to patients in Group III was meralluride. Each of the patients in this group received 2 cubic centimeters on the first day of therapy. Duration of therapy varied from seven to 31 days in Group I; from three to 31 days in Group II, and from three to eight days in Group 3. One patient in Group III was treated for 20 days. All of the 31 patients in Groups I and II were on low salt diets.

CONGESTIVE HEART FAILURE

WEIGHT loss in the 21 patients receiving hydrochlorothiazide* alone, averaged five pounds. Systolic blood pressure decreased from an average of 154 at the onset of therapy to an average of 136. This represents an average decrease of 18. Diastolic pressure decreased from 92 to 81, an average drop of 11. Arterial blood pressure was lowered from an average of 113 to 99, an average decrease of 14. Pulse rate was frequently reduced from an average of 101 to 82 per minute, giving an average reduction of 19 per minute. General condition of patients on hydrochlorothiazide* alone was markedly improved at the end of therapy. Their edema had either disappeared or was significantly decreased.

Hydrochlorothiazide* and a single two cubic centimeter dose of meralluride was administered to ten patients with congestive heart failure. The average patient-weight of 151 pounds was reduced at termination of therapy to 138, an average reduction of 13. Systolic blood pressure at the onset of treatment averaged 162 and at termination the average was 128, a reduction of 34 millimeters. Diastolic blood pressure was decreased from an average of 93 to 79, an average decrease of 14 millimeters. Mean arterial pressure was lowered from 116 to 95, a decrease of 21 millimeters. Pulse rate was reduced from 110 to 80 per minute. At termination of therapy, the general condition of all patients in this group was markedly improved. Edema had either disappeared or had greatly diminished.

10. Ford, R. V.: Annals of the New York Academy of Science, 71:397 (1958).

11. Porter, G. A., and David, H. A.: American Journal of Medical Sciences, 240:417 (October) 1960.

12. Brest, A. N., and Likoff, W.: American Journal of Cardiology, 3:144 (Feb.) 1959.

13. Brest, A. N.: International Medical Record, 172:450 (Aug.) 1959.

14. Brest, A. N., and Likoff, W.: *Diseases of the Chest,* 38:2 (Aug.) 1960.

When results in the 21 patients treated with hydrochlorothiazide* alone were compared to those ten who were treated with hydrochlorothiazide* in addition to one dose (2 cubic centimeters) of meralluride, it was found that meralluride markedly potentiated the action of hydrochlorothiazide.* Hydrochlorothiazide* alone gave an average weight loss of 5 pounds. Hydrochlorothiazide* plus a single dose of meralluride increased weight loss to 13. When one drug (hydrochlorothiazide*) was given the systolic blood pressure averaged a decrease of 18 millimeters and the diastolic pressure averaged a decrease of eleven. When both drugs were given, the average fall was: systolic 34, diastolic 14 millimeters. Mean arterial pressure was decreased by 14 on hydrochlorothiazide,* but when both drugs were given it was decreased to 21. On hydrochlorothiazide* alone, the pulse showed an average reduction of eleven. When hydrochlorothiazide* plus one dose of meralluride was given, average reduction in frequency was 30. These comparisons are striking considering that diuresis was so markedly improved by only one dose of meralluride. Furthermore, there was no increase in untoward reactions.

One patient is worthy of special notation. He was hospitalized one month before the onset of this study with congestive heart failure secondary to arteriosclerotic cardiovascular disease. During that period he received meralluride (2 cubic centimeters) every other day for seven days. Initially he did not respond to the mercurial diuretic. A pleural puncture was performed and 1,500 cubic centimeters of fluid were withdrawn. Following this, a remarkable decrease of edema occurred in all serous and subcutaneous tissues. His pericardial effusion and tachycardia subsided. Weight decreased from 200 to 157 pounds, a loss of 43 pounds. Blood pressure dropped from 130 systolic, to 120, and diastolic from 75 to 70; mean arterial pressure decreased to 87 from 93; his pulse rate from 90 per minute to 80 per minute, a reduction of 10 in pulse frequency. There were no observable side effects.

TOXEMIA OF PREGNANCY

The twenty-five patients with toxemia of pregnancy were each given 50 milligrams of hydrochlorothiazide* twice daily as a diuretic. When indicated, reserpine, reserpine-hydralazine and sedation were also administered. Seven women received only hydrochlorothiazide,* while nine were given reserpine 0.25 milligrams, two or three times a day. One patient received reserpine-hydralazine in addition to the hydrochlorothiazide.* Phenobarbital was the sedative given to 14 of the 25 patients. Doses ranged from grains ¼ to 2½ two or three times a day.

At the termination of therapy, all 25 patients were discharged in good condition. Their edema had either completely disappeared or was manifestly decreased. No untoward reactions occurred to any patient in this group.

REACTIONS

Few untoward reactions to hydrochlorothiazide* occurred during this study.

One patient reported mild headache and nausea. One showed hyperuricemia which disappeared when hydrochlorothiazide* was discontinued. One showed symptoms of hypochloremic alkalosis. This was corrected by the administration of ammonium chloride for three days. During this period, acetazolamide was substituted for the hydrochlorothiazide.* When the hydrochlorothiazide* was reinstated, no further side effects were observed. Fourteen patients had noticeable changes in electrolyte balance although clinical signs of toxicity were absent. When necessary, low serum potassium levels were prevented by the judicious administration of potassium chloride. Blood urea nitrogen was mildly elevated in seven patients with congestive heart failure and in six patients with toxemia of pregnancy, yet not one of these 13 patients evidenced any clinical symptoms.

Serum uric acid was increased in seven patients. In two cases it was extremely high without any clinical signs or symptoms of gout. One case with a serum uric acid level of 14.2 developed symptoms of hyperuricemia. Among women with toxemia of pregnancy, 16 had an elevated serum uric acid level. The level in one was 15.2 mg., but there were no clinical signs or symptoms of gout. There was

some increase in serum uric acid levels in all 56 patients studied. Patients with a serum uric acid higher than 8 milligrams per cent were encouraged to drink ample amounts of fluids to prevent renal complications. This regimen seemed effective. When the hydrochlorothiazide* was discontinued, the serum uric acid levels returned to normal within two or three days. Reasons for these elevations are not clear, although such effects may be observed with all "thiazide" derivatives.

SUMMARY

THE diuretic effects of hydrochlorothiazide* were studied in 56 patients. Thirty-one had congestive heart failure. Twenty-five patients had toxemia of pregnancy. The drug was administered orally in a daily dosage of 50 to 100 milligrams.

Results demonstrate that the drug has a marked diuretic effect on patients with excessive fluid accumulation. A pronounced decrease, or complete disappearance of edema occurred. A dramatic potentiation of the action of hydrochlorothiazide* occurs with the concomitant administration of meralluride.

CONCLUSIONS

1. Hydrochlorothiazide* is a potent diuretic agent in the treatment of congestive heart failure and toxemia of pregnancy when the elimination of excessive fluid is required.
2. Pulmonary and peripheral edema are actively reduced within a very short period.
3. Hydrochlorothiazide,* when combined with antihypertensive drugs, produces dramatic decreases in elevated blood pressure.
4. Hydrochlorothiazide* is markedly potentiated by a single dose of a parenteral mercurial, a fact which may be of clinical significance when the need for rapid diuresis is urgent.
5. Diuretic effect is potent and prompt in onset, of long duration, with an extremely low incidence of untoward reactions. It is a valuable and safe agent in the management of diseases requiring the massive elimination of excess fluids.

Acknowledgment: I am indebted to M. L. Arfaa, M.D., of the Obstetric Division of Martland Medical Center, Newark, New Jersey, for her cooperation in studying the effects of hydrochlorothiazide* in toxemia of pregnancy. I stress my appreciation for guidance and supervision of Dr. Joseph Fobes, the Director of Medical Education at Martland Medical Center, and Dr. Marchand, the Medical Coordinator there.

155 Jefferson Street

Incentive in Drug Research

Effect of compulsory generic name use on the ethical drug makers would be profound, say industry spokesmen. Gone would be the incentive to make the highest possible quality products; minimum standards would suffice. The incentive to improve existing drugs would disappear. There would be little incentive to develop dosage forms which could benefit relatively few people, and there would be little incentive to distribute a product to areas where statistics show sales would be relatively low. The most expensive drug is the one you can't get when you need it . . . And incentive and money to do research toward new drugs to lick the as yet incurable diseases would be lacking. The question then arises: where would tomorrow's drugs come from?—*Chemical & Engineering News,* June 13, 1961.

Letters to The Journal • • •

Postmortem Controversy

Facetiously, one can regard postmortem controversy as a dead subject. Yet it presents a many-faceted problem for which the medical profession has as yet proposed no equitable solution. The autopsy load of the hospital pathologist is increasing. I know of one hospital pathologist who is assuming responsibility for over 600 postmortem examinations annually. The work is not being done either to his own individual satisfaction, nor to the satisfaction of the interns and residents to whom he is able to shift part of the load. Histologic study of postmortem tissues from such a large number of cases is practically impossible, inasmuch as his responsibilities extend to other areas of the Department of Pa'ho'ogy.

This work load is a tremendous financial burden to any institution. Facilities must be provided, salaries of morgue assistants must be paid and funds must be available to cover pathologist's time and the salaries of the technicians who process tissues. The cost of adequate refrigeration, heat, light, water, gowns, gloves and aprons is hugely greater in an institution doing 600 postmortem examinations annually than in one doing one hundred. It is unfair to expect that the cost of this free work should be absorbed either by an individual pathologist or a Department of Pathology; or that it be tacked on to the patient's bill as room rent or daily hospital charge.

That the pathologist should select cases for necropsy examination does not appear to be proper. After all, it is the unstudied cadaver which retains the most fascinating discoveries. We can recall patients who succumbed to tetanus and (despite surgical debridement of neck wounds) necropsy disclosed visible fragments of thorny rose bush embedded in the deep muscles of the neck. I have known of a child dying of obvious intestinal obstruction where necrospy showed perforation of the bowel due to Ascaris Lumbricoides; aged patients who succumbed with a history of severe headache and necropsy revealed either unsuspected staphylococcic meningitis or torulosis. Any competent pathologist can recall cases of clinically undiagnosed tuberculosis, neoplasia, or specific infections which a thorough autopsy has brought to light. It is impossible for the pathologist to say: this autopsy will be educational, as well as revealing previously undisclosed knowledge to the clinician, while another will be routine. The necropsy examination is educational and it is apparently for this reason that the American Medical Association insists that hospitals maintain adequate facilities and accomplish whatever the work load of the pathologist may be.

Every hospital wants to be a teaching institution and consequently of greater benefit to the community which it serves, as well as to the overall plan of education in medicine. It would thus appear reasonable to suggest that funds contributed annually to the American Medical Association be dispersed to the local institutions which have to carry the burden of a tremendous autopsy service. Such action would enable these areas to secure additional help and to maintain high standards of necropsy work. This suggestion appears reasonable. Inasmuch as it is the American Medical Association which has been setting standards, the man who is going to call the tune should be willing to pay the piper.

Community health is benefited by the performance of necropsy examinations by pathologists who work in a local hospital. Surely local communities should respond by providing funds in their tax budgets to be turned over to the community hospital as a token of appreciation for its contribution to the public health and welfare of the area it serves. Such appropriation will assure the maintenance of adequate standards of necropsy examinations to the community, providing they are performed by competent pathologists.

These comments may not solve the controversy about postmortem examinations; however, as John Adams once said, "liberty can be achieved only through public education, discussion and free expression of thought by all men." It is in this sense that I present the

subject of the autopsy problem, while noting a few thoughts relative to some aspects of the autopsy work load. Virchow and Rokitansky did their studies without benefit of enzyme analysis, Coulter Counters and Coombs tests. Their lives must have been relatively free from complications and controversy.

THOMAS K. RATHMELL, M.D.

Psychotherapy: The Real Issue

In the October 1961 JOURNAL, Dr. J. L. Morrow published an article urging physicians to send patients needing psychotherapy to psychiatrists rather than to psychologists. The following letter is written by Stanley Moldawsky, Ph.D.

As president of the Essex County Society of Clinical Psychologists in Private Practice, I wish to discuss an article by Dr. Lloyd Morrow appearing in the October 1961 JOURNAL. Entitled "Physician's Dilemma: Psychotherapy," it deals with the referral of patients for psychotherapy. It counsels physicians to refer only to psychiatrists.

The objective of psychotherapy is to aid the patient to learn about unconscious conflicts at the root of the pain which brought him into treatment. In bringing them into consciousness through the therapy relationship the patient is given a second chance as it were to resolve these conflicts. These unconscious processes are irrational and do not follow the laws of rational thinking; hence common sense approaches are inadequate to deal with the problem.

Psychotherapy is a highly technical, artistic skill requiring extensive training, courage to face the inner truths which most others have repressed; a deep love of honesty; and a sincere *interest* in people. The problem as we see it is not as simple as Dr. Morrow's position supposes. Adequate referral depends upon locating people who have had the relevant and highly specific training that psychotherapy demands. This training is not guaranteed with the granting of either an M.D. or Ph.D. Likewise, the holder of one of these degrees hasn't *ipso facto* been *trained* in this skill whether he be psychiatrist, psychologist or general physician. The training includes being carefully supervised in the treatment of neurotic, psychotic, and borderline individuals; a personal analysis of the therapist; numerous seminars specifically devoted to the theory of personality development, theory of treatment, Freud's metapsychology and so forth. Many of the practicing psychotherapists in the area fulfill all of these training requirements. Many fulfill part of the n and many, unfortunately, fulfill *none* of these. It is generally agreed that the most significant part is the personal analysis. Because the general public knows little of these requirements, and because many physicians are unaware of the extensive training needed, stereotypes abound in the minds of the referring public. Dr. Morrow[3] avoids this basic issue of training and personality and pleads—"for safety and for adequate medical treatment—only the psychiatrist can be entrusted with your patients."

This issue of whether psychologists can or cannot be entrusted with psychotherapeutic responsibility has received some public clarification on a national level recently in the *Action for Mental Health*.[2] This 100,000 word report to Congress, the Governors, and Legislatures of the United States by the Joint Commission on Mental Illness and Health, recommends: "That psychoanalysis and allied forms of deeply searching and probing depth psychotherapy must be practiced only by those with *special training*, experience and competence in handling these technics without harm to the patient (namely, by physicians, trained in psychoanalysis or intensive psychotherapy *plus those psychologists* or other professional persons who lack a medical education, but have an aptitude for, *adequate training* in, and demonstrable competence in such technics of psychotherapy)." It should be noted that the Joint Commission was made up of mental health experts from different disciplines including the president and prominent members of Dr. Morrow's own professional group, the American Psychiatric Association. It is true that nonmedical psychotherapists cannot treat the patient's organic difficulties but it is equally true that they know enough and are responsible enough to refer to appropriate medical sources when it is indicated. Growing public support for this position is evidenced by the above recommendation of the Joint Commission and the fact that 16 states now license or certify psychologists. The practicing psychologist enjoys good relations with many medical specialists and they have learned through experience that they can trust each other. Dr. Morrow's mistrust represents a minority viewpoint in this respect.

The area of psychotherapy has grown and includes an enormous literature. New concepts have slowly evolved and old ones reworked. Thomas Szasz, M.D., a well-known psychiatrist and psychoanalyst states[5] "My aim—is to suggest that the phenomena now called mental illnesses be looked at afresh and more simply, that they be *removed* from the category of illnesses, and that they be regarded as the expression of man's struggle with the prob-

lems of how he should live." He further says that mental illness is a "convenient myth." It is a labeling of malfunctioning psychologic processes as *illness* when their definition is understood in terms of psychosocial, ethical, and legal concepts, not medical.

Davidson [1] spoke about marital discord or hostility to an employer and then states—"We are practicing magic if we think we can make these deviations into sicknesses merely by listing them in our own little book." (He refers to the *Diagnostic and Statistical Manual of Mental Disorders.*) By using the label of illness, and then defining psychotherapy as a medical treatment for illness a preempting takes place that confuses the basic issue. Szasz [4] defines psychotherapy as follows: "Psychotherapy consists of one person *influencing* another (or perhaps several others) by means of processes which may include one or several of the following means: talking, informing, advising, recommending, interpreting, explaining, promoting, exhorting, forbidding, threatening, and coercing." This definition includes so many diverse processes that it is impossible to restrict psychotherapy to medicine and equally impossible to limit it to psychology.

It is general practice in psychoanalysis and psychotherapy for the medical therapist not to perform medical examinations nor treat current medical conditions himself during the course of the psychotherapeutic relationship. After many years of specializing in psychotherapy, knowledge of medical treatments is less than adequate so the therapist prefers to refer to a more up-to-date medical colleague. This holds for most therapists.

Psychology shares with the medical profession the problem of screening within its own ranks the properly qualified from the mere degree holders. The existence of specialty boards such as American Board of Examiners in Professional Psychology, State Certification Boards, and ethics committees, offer basic protection to the public that standards of competence are being upheld by the practitioners.

Collaborative and cooperative effort among psychologists, psychiatrists and other specialists is typical practice in this area. In recognition that each profession has distinctive qualities to offer the public, members of allied professions have grouped together to provide the varied services different patients require. Hence, there are a number of well-functioning groups practicing in this manner in New Jersey. Perhaps this is a new trend which overrides interprofessional competitiveness. It bodes well for the future. It demands a maturity on the part of all the participants.

It calls for a willingness to set aside professional jealousies and to respect the integrity, independence, and unique personal skills of each individual.

Based on the experiences of long-practicing psychologists that such interprofessional good-will does in fact exist it would seem that the "Physician's Dilemma" is no more than Dr. Morrow's dilemma!

STANLEY MOLDAWSKY, Ph.D.

Getting an M.D. degree does not guarantee that the holder has had training in psychotherapy. However, a psychiatrist would certainly have had such training in spite of Dr. Moldawsky's implication to the contrary. Our correspondent says that training in psychotherapy includes personal analysis. While Dr. Moldawsky is entitled to this feeling, it is certainly not universal opinion—particularly for and among psychotherapists who do not do psychoanalysis. The reference to *Action for Mental Health* is misleading. Dr. Moldawsky's point is that (1) The American Psychiatric Association helped finance this project; (2) The report accepted the propriety of psychologists doing psychotherapy; therefore (3) The American Psychiatric Association believes that psychologists may do unsupervised psychotherapy; and (4) Therefore Dr. Morrow is out of step with his own professional organization. Item (3) does not logically derive from the major and minor premises of items (1) and (2). The American Psychiatric Association has unequivocally supported the position which Dr. Morrow takes; but has helped finance the report which appeared in *Action for Mental Health* even though it doesn't agree with it. That 16 states certify or license psychologists means nothing in this context. States also license beauty parlor operators, plumbers and night clubs. Dr. Szasz's definition of psychotherapy would seem to have little relevance here. Obviously if you define it, as he does, to include "explaining, promoting, forbidding, threatening and coercing," no one will claim it as a medical monopoly. The last phrase of Dr. Moldawsky's letter scarcely comes under the heading of logic at all.—Editor.

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Obituaries • • •

DR. WILLIAM A. COGGER

On January 11, an untimely heart attack prematurely took the life of Dr. William A. Cogger, at the age of 37. A Rutgers graduate, Dr. Cogger received his M.D. in 1954 from the New York State Medical College. He then interned at the Muhlenberg Hospital in Plainfield. On completing his internship, he entered private practice in Watchung, soon becoming school surgeon and borough physician there. Dr. Cogger saw Army service on foreign duty between 1943 and 1946. He was a general practitioner.

DR. LEO J. FITZPATRICK

Dr. Leo J. Fitzpatrick of Teaneck died on December 14, 1961 at the age of 59. He was born in Bayonne, where he received his early education. He received his M.D. from Long Island College of Medicine, and served his internship at Holy Name Hospital, Teaneck. Until 1942, he practiced in Ridgefield Park.

At the beginning of World War II, Dr. Fitzpatrick entered the military service, and was assigned to the 2nd Auxiliary Surgical Group as Chief of Anesthesia. He saw service in the African, Italian and French campaigns, and was awarded a special commendation from the Surgeon General. After two years of foreign service he was assigned to the England General Hospital as Director of Anesthesia. He remained there until the end of the war.

Returning to private practice in 1946, he became Chief of Anesthesia at Holy Name Hospital, Teaneck. He was also Director of Anesthesia at Bergen Pines County Hospital and was on the consulting staff at Halloran and East Orange Veterans Administration Hospitals. Dr. Fitzpatrick was a Diplomate of the American Board of Anesthesiology and was a Fellow of the American College of Anesthesiology. He was a past president of the New Jersey State Society of Anesthesiologists.

His many publications included *Management of Thoracic War Injuries* and *Nerve Block in Treatment of Thoracic Injuries.*

In 1958, Dr. Fitzpatrick was elected president of the Bergen County Medical Society.

DR. J. HARRY McCROSKERY

More than 55 years of service to New Jersey terminated on January 22 with the death that day of Dr. J. Harry McCroskery, one of Essex County's senior physicians. Born in 1880, he received his M.D. at Columbia University in 1905 and moved to East Orange to enter general practice in 1909. A year later he was appointed to the staff of Orange Memorial Hospital and served there in all grades, being president of the medical board from 1940 to 1943. Dr. McCroskery was, for many years, director of the Outpatient Department at Orange Memorial. He was also a long time officer of the East Orange Board of Health, and active in civic affairs, particularly in the Boy Scout movement, which in 1939, awarded him a special medal for interest and leadership.

DR. LOUIS E. NORWICH

Dr. Louis E. Norwich died on December 9, 1961 at the St. Francis Hospital in Jersey City. He was 65 years old at the time of his death. He was senior surgeon to the Bayonne Police Department, an agency he had served for almost a quarter of a century. He received his M.D. at Temple University in 1921 and was active in civic, fraternal and business affairs in Hudson County. Dr. Norwich was a general practitioner affiliated with St. Francis Hospital in Jersey City.

DR. PETER PAGANO

Dr. Peter Pagano, formerly of Ridgewood, New Jersey, died on November 30, 1961 at his summer home in Millbrook, N. Y. Illness had forced him to retire two years ago. Born in New York City in 1896, he came to Ridgewood early in life. World War I interrupted his studies at Princeton University. He was wounded in action while serving in France. He received his M.D. from the Medical College of Virginia in 1927, and interned at the Richmond Hospital.

In his earlier years of general practice, Dr. Pagano was affiliated with the Paterson General Hospital. In 1951, with the opening of the Valley Hospital in Ridgewood, he became an active staff member, his main interest being in ophthalmology. Peter Pagano was one of the greatest all-round athletes to pass through the Ridgewood High School. His proficiency in all the major sports was a delight to his fans. He was not only an

individual star; he was a team player who, in the words of one of his old colleagues, never let down the team to aggrandize himself.

DR. ENRIQUE DEL C. SMAINE

Dr. Enrique Del C. Smaine, a 1929 graduate of Marquette University, died on November 29, 1961 at the age of 62. He interned at the Jersey City Medical Center in 1930 and opened an office for general practice in Carlstadt, New Jersey in 1931. He became active in the affairs of the Bergen County Medical Society and was, for a quarter of a century, Carlstadt's School Surgeon. He was a member of the local Board of Health and served as a major in the Army Medical Corps, being on duty in the Pacific area from 1942 to 1945.

DR. ANDREW B. VANDERBEEK

At the fine age of 91, Dr. Andrew B. Vanderbeek died on January 3, 1962. He was born in Jersey City during the presidency of Ulysses S. Grant, and in 1901 received his M.D. from the medical school of the University of Maryland. He opened an office in Paterson in 1902 and served the people of that area for more than 54 years, not retiring until 1956 at the age of 85. Dr. Vanderbeek was a pioneer in otology and ophthalmology. He was the first such specialist on the staff of Barnert Memorial Hospital. Dr. Vanderbeek was, for 50 years, an elder of the Presbyterian Church. He was a diplomate in both otology and ophthalmology —one of the first doctors to earn his Board diploma in either of those specialties. He was, or had been, senior otologist or ophthalmologist at all three hospitals in Paterson.

Announcements • • •

Annual Dermatology Lecture

"Dermatologic Aspects of Mast Cell Activity" is the title of the next Howard Fox Memorial Lecture. This program will be heard at New York University's Alumni Hall, 552 First Avenue, New York City, on Tuesday, May 8, 1962 at 4 p.m. Speaker will be the distinguished European dermatologist, Dr. Gustav Asboe-Hansen, director of Copenhagen's Connective Tissue Research Institute. You are invited to attend.

Courses in Heart and Lung Diseases

Two intensive courses in heart and lung diseases are announced for the fall of 1962. One, in Philadelphia, runs from September 17 through 21. The other, in New York City, is scheduled for the four-day period beginning on November 12. Tuition is $100, but members of the American College of Chest Physicians will be entitled to a reduction of $25. For details write to American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Conference on Perinatal Mortality

Wednesday, April 4, has been set aside for a conference on perinatal mortality sponsored by the Academy of Medicine in conjunction with the New Jersey State Department of Health. The meeting will be held at the Essex House, Lincoln Park, Newark, and will begin promptly at 2 p.m. The afternoon session will adjourn at 5:30 p.m. and the evening meeting will begin at 8:00 p.m.

The faculty will consist of six distinguished obstetricians and pediatricians. The first paper "Risks of Prenatal Life" is by Dr. Harry Prystowsky of the University of Florida. He will be followed by a discussion of respiratory problems of the newborn, led by L. Stanley James, M.D. of Columbia University. Other subjects will be the risks of prematurity and the hazards of blood incompatibility.

The last three papers will be presented by Dr. Lewis Gluck of Yale University, Fred Allen, Jr., M.D. of Harvard, and William A. Silverman, M.D. of Columbia University.

At the conclusion of the formal papers there will be a summation by Professor Clement A. Smith of Harvard.

For further details write to Dr. Milton Shoshkes, 505 Elizabeth Avenue, Newark 12.



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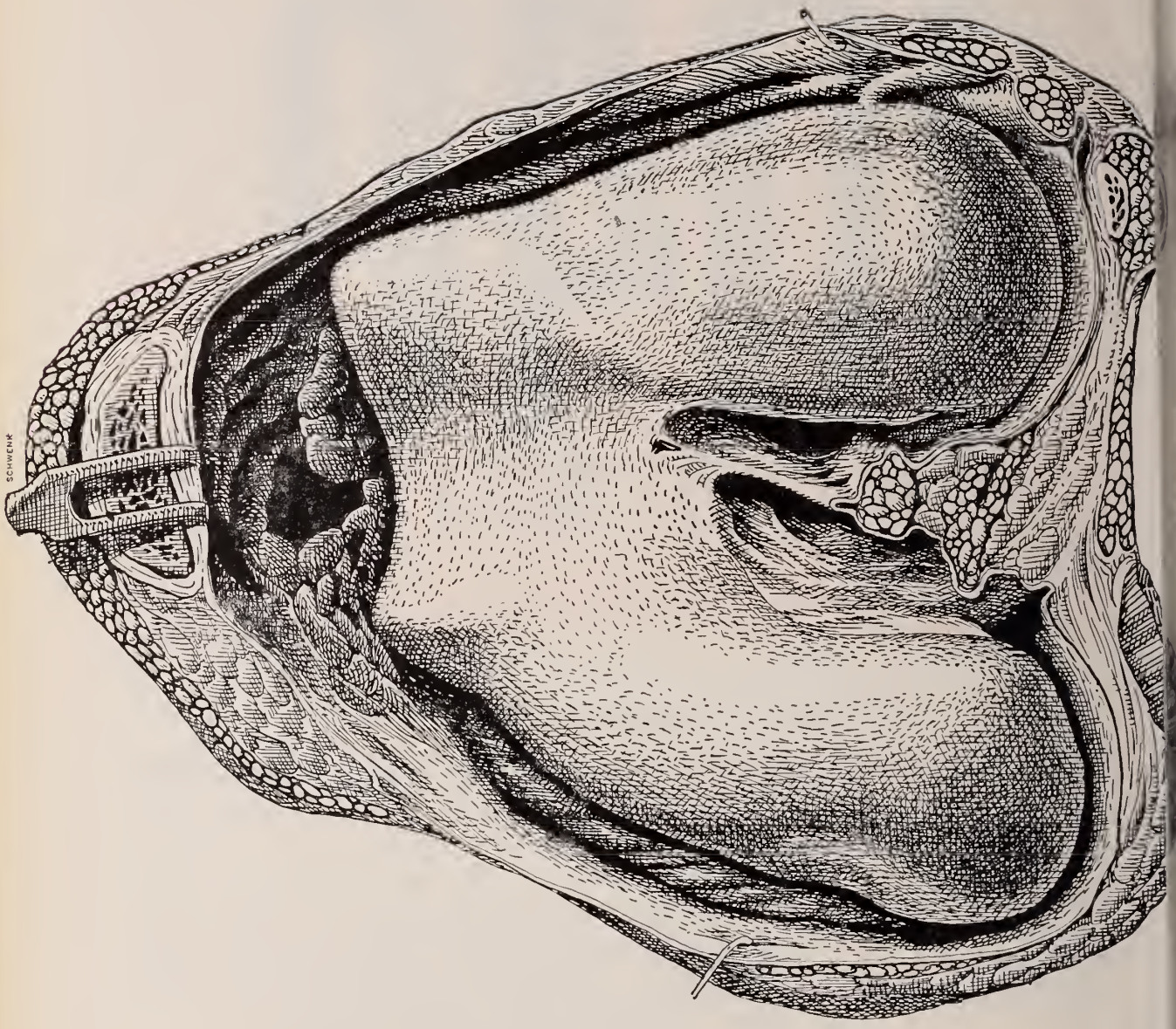
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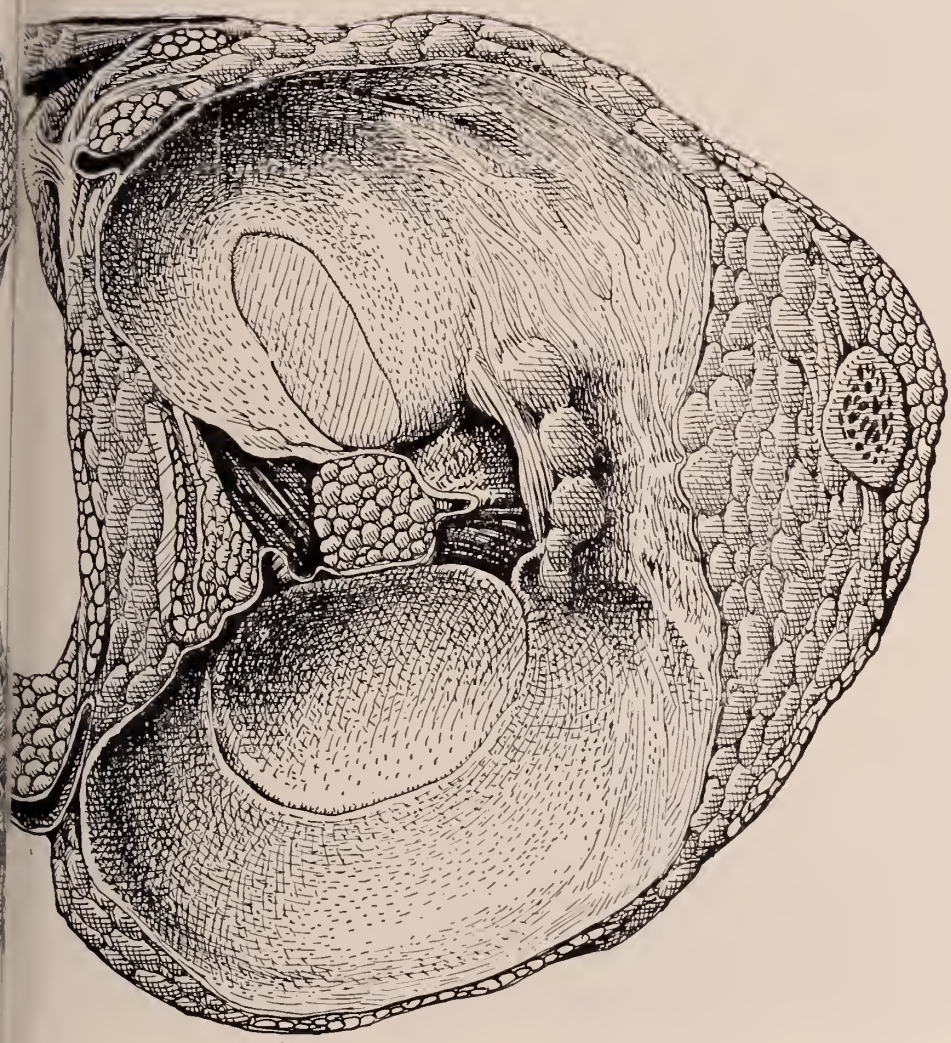
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Editorials • • •

Freedom of Professional Choice

We are much concerned about preserving the patient's free choice of physician. Less attention has been paid to the doctor's freedom to choose among alternate treatment methods. Legal difficulties sometimes arise when a physician elects a method which, in his judgment, he considers appropriate, but which most doctors don't like. What then? In this connection, the New York decision in the Foxluger case (Foxluger vs. New York 23, N. Y. Misc. Second 933) is interesting.

The Court of Claims of New York, in dismissing a claim against the State for alleged negligence in the administration of electric shock therapy to a patient in a State hospital, quoted with approval from the decision in *Gielskie* versus *New York*.

The emphasis which the Courts place on the *Gielskie* decision is of importance to the practice of medicine because it places in proper perspective the obligation of the physician to his patient and the exercise of his judgment in selecting a method of treatment.

The claimant in this action was admitted to the State hospital on June 4, 1946. The mental diagnosis was involution melancholia. On the recommendation of the clinical director of the hospital, electric shock therapy was used. The result obtained, so far as the mental illness was concerned, was satisfactory, but the therapy caused a fracture of the right humeral neck after the first administration and an impacted fracture in the neck of the left humerus on the final treatment.

The fracture of the right humerus was not discovered until August 15, although the injury was sustained on June 29. The x-ray revealed no fracture. An examination of the right shoulder was made by doctors who diagnosed the injury as a tear of the right supraspinatus. Following these examinations,

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the electroshock treatments were continued and were terminated on July 28.

The Court ruled that the State was *not* negligent in failing to discover the fracture of the right humerus, relying on an earlier decision which laid down the rule that "the State is not responsible for an honest error of professional judgment made by qualified and competent doctors employed by them." (*St. George v. State of New York*, 283 App. Div. 245, aff'd 308 N.Y. 681)

It noted that the sole question is whether the State was negligent in failing to use a relaxant drug before administering the second and subsequent electric shock treatments after the employees of the State knew that the patient had been injured during the first treatment.

The Court said that regardless of the ultimate finding, this case must be decided on whether the State used proper treatment. Successive treatments at regular intervals are necessary if this therapy is to succeed. In 1956 some doctors were using relaxant drugs as routine when administering electric shock treatments. Many other doctors were *not* using the relaxant drug, fearing the dangers of the unknown reaction more than the probability of injuries which would include fractures.

The Court in then reaching its decision to dismiss the claim quoted approvingly from the *Gielskie* case, as follows:

There is no legal authority which says that a physician must use what *some* doctors consider the best method if a method which is accepted by respectable medical authority is adopted.

We do not toss aside the State's argument that there are two schools of medical thought upon the method of administration. Medical opinion and medical textbooks differ. By honestly accepting one field of respectable medical opinion, though other, and perhaps more numerous, medical opinions may differ, does not constitute negligence simply because in a particular case the result was disastrous. To hold the State liable under the circumstances presented here would mean that either the State must render no public service at all or be an insurer against any bad results that might follow.

Weight Control: A Physician's Job

If we doctors don't do the job, everybody and his brother is going to get in on the act of controlling obesity. This is clearly a physician's responsibility. Indeed, it overlaps several well recognized medical specialties: gastroenterology, gynecology, endocrinology, internal medicine, metabolism, pediatrics, pathology, and psychiatry—to name a few. For some reason, many clinicians have hesitated to do serious work in this field. Into the resulting vacuum have come a host of diet faddists, physical culturists, cosmetologists, gymnasts, dance instructors, masseurs, nonmedical nutritionists and a spectrum of crackpots promoting a variety of fancies.

Yet this is a medical specialty worthy of any physician's interest and challenge. The problem is obviously a big one. The practitioner willing to devote time to the study of nutrition and the control of overweight will find his patients grateful, the results visible, and himself a pioneer in what may well become a new medical specialty. Perhaps it will be called steriatrics,* from the Greek for "physician to the fat." (If there isn't such a word

*J. E. Schmidt, M.D., Chairman of the National Association on Standard Medical Vocabulary, and a distinguished lexicographer, suggests that *bariatrics* would be a better term than "steriatrics." This is from the Greek *baros*, weight; hence a bariatrist would be a physician interested in weight control. *Steriatrics*, Dr. Schmidt believes, would be more properly applied to the study of fats, as chemicals than to the study of fat people. Take your choice.—Editor.

now, there ought to be; and it sounds as if it really belongs to the parade of medical specialties: we have pediatrics and ephebiatrics and geriatrics; why not steriatrics?)

As a specialty it has some real advantages. There should be no night calls or emergencies; none of the steriatrist's patients should die. The doctor will find himself involved in many branches of medicine. He will have to learn a lot about the human body. He cannot learn it in ten easy lessons, since he will have to acquire some grasp on biochemistry, metabolism and endocrinology, as well as applied psychology. He will have an opportunity to develop group psychotherapy, for food addiction, like alcohol addiction, is handled well in groups. Misery loves company, and each victim reassures and challenges the other.

Some clinicians look down their noses at steriatrics. They see it as a kind of cosmetology, unworthy of the physician's attention. This is an unfortunate and unjustified snobbery. The obese person belongs in a doctor's office. Let us not drive him to the cultist by assuming that it is *infra dig* for the physician to treat this problem. It isn't. On the contrary, a well-rounded patient will develop a well-rounded doctor.

Obesity is rapidly becoming a major health problem. An accolade is due the physicians who realize that it is their responsibility to tackle it.

Taking the "Mal" Out of Malpractice†

Your maid is standing on a ladder, dusting a fixture. She falls and sprains her ankle. She files and collects a workmen's compensation claim. You have been found "liable" under the law; that means "liable" to compensate her, which you do through your insurance company. You have not, of course, been found "guilty" of anything. You are not stigmatized as "negligent".

A patient develops a rash from a new medication and sues you. Now you are charged with "negligence". The pleadings, indeed, assert that you recklessly or negligently or with gross carelessness did something harmful. This is malpractice. Whereas your feelings were not hurt by the maid's compensation claim, you are deeply hurt by the patient's allegation of your "negligence".

The "mal" in "malpractice" is the "mal" of malicious, malignant, and malign. It means "evil". One of the great psychological factors in the entire malpractice problem is the semantic one. Doctors themselves want to avoid the whole dirty word "malpractice" and say, instead, "professional liability".

That's the problem. The answer would seem to be to develop the concept of negligence without fault; or, better yet, liability without negligence.‡ Once we could accept the idea that a person is entitled to indemnity for an untoward result, without any stigma of fault or negligence, we can view the problem dispassionately. Indeed, it might well be disposed of, like workmen's compensation, by administrative (not judicial) tribunals, without juries, with expert assessment of damages, and with no tossing around of words like "recklessly" and "negligently".

†Paraphrased from an item in the July 1961 *Riss* (the Journal for residents, interns and senior students).

‡For a thought-provoking discussion of this see page 389 of the *Paraquelw a of Law* by David Louisell, L.L.B. and Harold Williams, M.D., Rochester 14, N. Y. Lawyers Cooperative Publishing Company.

ROBERT W. TILNEY, JR., M.D.

Morristown

Head and Neck Cancer*

Diagnosis and Treatment with Emphasis on the Significance of a "Lump in the Neck"[1]

A lump in the neck is one of those common symptoms which we often dismiss lightly. It may be the pilot of a metastatic carcinoma.

THERE are two ways to improve the cure rate in cancer of the head and neck. One is to diagnose it earlier so that treatment may be started sooner. The other is to acquire better treatment technics. Purpose of this paper is not only to tell about current improved treatment, but also to point out the steps to be taken by the doctor who first sees the patient with head and neck cancer to insure earlier diagnosis.

A "lump in the neck" is an unscientific term but one which we can all picture readily. The patient uses this as his chief complaint. It may be a symptom of cancer of the head and neck.[2]

Here is a tabular listing of possible causes, a scheme for differential diagnosis.

INFLAMMATION

Acute Lymphadenopathy due to infection in mouth or pharynx, larynx and nose, acute sialadenitis.

Chronic Lymphadenopathy due to tuberculosis, Boeck's sarcoid, chronic sialatis with or without calculosis of the salivary ducts.

NEW GROWTHS

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Malignant: *Primary*: Lymphoma—(Lymphosarcoma or Hodgkin's) thyroid or salivary gland tumors, sarcomas of the soft parts, i.e., angiosarcoma, fibrosarcoma, liposarcoma, myosarcoma, neurigenic sarcoma and spindle cell sarcoma (origin unknown), chordoma or branchiogenic carcinoma, carotid body tumor, melanoma.

Metastatic carcinoma of cervical lymph nodes from the oral and nasal cavities, pharynx, larynx, paranasal sinuses, salivary glands, thyroid, skin of face and scalp, or even from a viscus below the clavicle.

CONGENITAL DEFECTS

Branchiogenic cysts, thyroglossal cysts.

VASCULAR DEFECTS

Aneurism, arterio-venous fistulae.

As indicated above, the list of possible diagnoses is long. When one of these infrequent

*Read May 16, 1961 at the Annual Meeting of The Medical Society of New Jersey.

1. Martin, H. and Romieu, C.: Postgraduate Medicine, 11:491 (1952).

2. Martin, H. and Morfit, H.: Surgery, Gynecology and Obstetrics, 78:133 (1944).

swellings is seen in one of our patients we may first think of a branchial cleft cyst because this may have been emphasized in medical school. However, statistically it is way down on the list. Most enlargements are swollen lymph nodes ("glands") due to metastatic cancer, the origin of which can often be found in the near vicinity. An enlarged lymph node, specifically a hard, asymmetrical mass over one centimeter in diameter in adults, which may (or may not) be fixed to the skin or underlying tissues, is often the presenting and only symptom of a small or occult epidermoid carcinoma of the mouth, nose, larynx or paranasal sinuses. This is true especially when the common benign conditions such as lipomas, sebaceous and other cysts of the neck, and acute lymphadenitis are ruled out by careful physical examination.

When a patient with a "lump in the neck" first seeks medical aid, either from a physician, dentist, osteopath, or chiropractor, the possibility of cancer is sometimes considered. However, the idea that it is a *metastatic* cancer with the primary lesion elsewhere, which also has to be taken care of to cure the patient, often does not occur with sufficient impact for the doctor to search for a primary tumor by examining the patient's mouth with a strong light, palpating the base of his tongue and floor of the mouth or doing a mirror examination of the patient's larynx or nasopharynx. Instead, the tumor is thought of as a single entity, having its origin at the site of the swelling. A seemingly simpler, more direct approach is either to remove the enlarged node for histologic examination or refer the patient to someone else to remove it. The confrere continues the same course, forgetting that this swelling might be metastatic from a primary in the patient's upper respiratory or alimentary tracts. He also may neglect to search the patient for a primary tumor and probably does as he is asked to do—not realizing that his indiscriminate biopsy or node excision may make treatment more difficult and cure impossible.

If one excises a skin cancer or a cancer of the lip with normal tissue around it—that's the end of it; the patient is probably cured. Not so with this tumor of the neck. Because if it is metastatic disease, it is going to be controlled only if the primary tumor (with its associated lymphatic pathways) plus a normal uninvolved zone is removed—preferably in continuity. If this continuity has been damaged by previous lymph node removal or biopsy—which may disseminate neoplastic cells in the process, scar tissue forms and a complete excision of the area by a neck dissection is more difficult. Not only is there more likelihood of its being incomplete, but normal vital structures are needlessly sacrificed. If there is one positive palpable node in the lymphatic bed, there may be others that are occult, making a clean dissection of the lymph node bearing area mandatory for hope of cure.

IF, AFTER a search, the primary tumor is found in the mouth, it can be biopsied, a diagnosis made, and a definite plan of attack (to encompass both the mouth tumor and the metastatic node in the neck) can be carried out. If a primary tumor cannot be found, then an aspiration biopsy[3] of the enlarged node may be a profitable procedure. No harm will come from aspiration, and if the pathologist will make every effort to make a diagnosis with small bits of tissue, a diagnosis of metastatic epidermoid carcinoma can be made, and proper steps be taken to rid the patient of his disease. About 75 per cent of metastatic nodes of the neck are from a primary epidermoid carcinoma in the near vicinity, the parent tissue of which is squamous or pseudosquamous epithelium. Aspiration biopsy is a safe, inexpensive, and simple procedure that won't spread the disease, and will not scar the field and preclude definitive treatment. It is done with an ordinary 50 cubic centimeter syringe, and a Number 17 gauge needle with an obturator. A small opening in the skin over the lymph node is first made under local anesthesia with a Number 11 Bard-Parker blade. The needle is then in-

3 Martin, H. and Ellis, E. B.: Surgery, Gynecology and Obstetrics, 59:578 (1934).

troduced with the obturator in place into the substance of the lymph node. The obturator is then withdrawn and the syringe attached. The plunger is pulled back as far as it can be and held. The resulting negative pressure inside the syringe is sufficient to pull back tissue into the needle when it is repeatedly pushed into the enlarged lymph node. After the negative pressure is released by letting the plunger down gently the needle can be removed and the material inside the needle pushed out onto a slide or a piece of blotting paper with the obturator. This is then put into formaldehyde and sent through regular processing to paraffin. The friable consistency of a metastatic epidermoid lymph node makes aspiration easy. Several cores of the tumor can be aspirated into the Number 17 needle without difficulty. Although many thousands of aspiration biopsies are done yearly, tumor spread along the remaining tract is so infrequent that documented cases are almost non-existent.

Another symptom of head and neck cancer is an ulcerative lesion of the mouth. The first doctor consulted takes a look at this foul-smelling, chronically bleeding neoplasm. He thinks of the possibility of cancer, and drawing on his past experience of the awesome end results of such an ailment, tries to prove that this lesion is *not* a cancer. First, he may paint it with gentian violet; then antibiotics and vitamins are given. Dentures are adjusted. If this does not improve the situation, some or all of the teeth may be extracted. At last there is no escape, the lesion persists and progresses. There is only one thing left to do and that is to take a biopsy which reveals that the lesion is neoplastic. Fear of hemorrhage while cutting into the lesion may also be a deterrent to early biopsy; but, although these angry tumors (especially in the tonsil) look as if they will bleed profusely even if a small needle were inserted into them, much less a knife or a punch of some sort, a small sponge under pressure over the defect for a few moments will control the bleeding nicely. Sometimes months are lost before these tumors are diagnosed and before therapeutic measures can be taken in a forthright and determined manner to eradicate the process.

Making the diagnosis earlier in the disease is our one hope of increasing the cure rate from about 30 per cent to a higher level. This is also true for cancers of the nose, sinuses and nasopharynx. Asymmetry of the face, displacement of any eye or chronic closure of the nasal passages should make the first doctor consulted think of cancer and then take the proper steps to make a diagnosis—as soon as possible. But again the thought of laryngeal or paranasal sinus carcinoma is such a distasteful one, and the contemplation of treatment even worse, that all other methods available are first used to try to treat this ailment unscientifically rather than to make a diagnosis by a biopsy.

TREATMENT of cancer of the head and neck[4] whether by x-ray or surgery is still controversial. But it is generally agreed that nasopharynx cancer and recurrent cancer of the head and neck (if no further surgery can be done) must be treated by irradiation. On the other hand, because of the resistance of epidermoid carcinoma to irradiation, most physicians, including the radiologists, recognize the fact that if a primary tumor of the head and neck can be excised with a margin of uninvolved tissue along with its associated lymphatic pathways then this is the treatment of choice. Most of these tumors are easily excised. Operative risk is minimal, the disfigurement is less than expected, and if the surgeon plans a therapeutic procedure to eradicate the process at the first application of treatment, then a high yield of excellent results can be expected. To achieve this, the surgeon needs an optimistic attitude. He must be convinced that the first and primary consideration is to get the tumor out regardless of how difficult the closure may seem. When he embarks on such a program, it is his responsibility to see it through to the end, accepting the fact that he can cure about 35 per cent of his patients. Lack of conviction, temporizing, and delayed

4. Martin, H.: Surgery of Head and Neck Tumors. Hoeber-Harpers, New York (1957).

treatment together with indiscriminate neck nodes biopsy only serve to lower this figure.

Dispute between the radiologist and the surgeon is really now limited to two major areas: the base of the tongue, and the intrinsic larynx. The advantage of surgery is that the tumor can be completely removed in many instances together with its lymphatic pathways. Thus, when the pathologist has the specimen in his hand he can not only grade the disease as to the degree of malignancy, but he can also tell with considerable accuracy if the tumor has been completely removed with a surrounding zone of normal tissue. Also with surgery, there is usually less pain and discomfort, and the treatment is over within a shorter period of time.

Tracheotomy was undoubtedly the first operation accomplished in the field of head and neck surgery. This was done around the year 100 A.D. Repair of war wounds of the face was described in the literature up to the nineteenth century. Almost all operations done today were technically possible and were being done in the 1890's and early twentieth century; but due to discouraging operative mortality and morbidity this gradually defaulted to x-ray and radium treatment. Shortly after, this treatment was thought by many to be the answer to the sufferings of patients with cancer of the head and neck, so that in the twenty years prior to the last war, nearly all malignancies of this region were being treated by irradiation. However, enthusiasm for x-ray treatment started to fade when unsatisfactory end results and complications began to appear. Renewed interest in surgery came about when medical advances such as antibiotics, improved anesthesia, blood banks and the skin drum dermatone made surgery again worth a try. These advances were further spark-plugged by investigative teachers like Hayes Martin of Memorial Center in New York City, who, together with his colleagues and students, has had the courage and foresight to restore surgery to its present popular and increasingly accepted status. Radical surgery for the primary treatment of cancer of the head and neck region has made great strides since World War II, and is becoming more widely accepted as indicated in the increasing volume of scientific papers and text books now being published.

For many years, this type of surgery was carried on only in the few large teaching hospitals where it was considered experimental. Due to dissemination of operative technics and concepts of surgical management, this work is now being done in a greater number of hospitals, and in the hands of well-qualified surgeons it has found its way into the community hospital.

The figures displayed below come from the Morristown (N.J.) Memorial Hospital. Only two of these patients have gone as long as five years.

Epidermoid Carcinoma of Tongue, Floor of Mouth and Gingiva	19
Epidermoid Carcinoma of Larynx	11
Cervical Metastatic Disease from Head and Neck Cancer	11
Epidermoid Carcinoma of Face Involving Nose and Orbit	2
Epidermoid Carcinoma of Hard Palate	1
TOTAL (Morristown Memorial)	44

Here is a listing of the operations done on these 44 patients at Morristown Memorial Hospital:

Total Laryngectomy with radical neck dissection	5
Total Laryngectomy	4
Partial Laryngectomy	2
Hemi-Mandibulectomy with radical neck dissection	12
Radical neck dissection only	11
Marginal Resection of mandible with radical neck dissection	2
Radical Resection of maxilla	2
Total Laryngectomy, hemi-mandibulectomy, radical neck dissection	2
Total Mandibulectomy with radical neck dissection	1
Marginal Resection of mandible	1
Orbital Exenteration	1
Partial Resection of hard palate	1
	44

As indicated below, 26 of 41 patients are living and well. Here are the results to May 1, 1961:

Living and well without evidence of disease	26
Living with evidence of disease	2
Died of disease	9
Died of other causes—without disease	3
Died of other causes—with disease	0
Operative death	1
	41

SUMMARY

1. A lump in the neck is usually metastatic cancer, and little harm is done by approaching the problem as such rather than trying to prove that it is something other than neoplastic. First look for a primary tumor which is usually in the vicinity. If a primary tumor is found, biopsy it. If no primary tumor is found, aspiration biopsy of the enlarged node is the next step. Only if this is negative should the node be excised.

2. If the lesion and its lymphatic pathways can be extirpated surgically, this is the method of choice.

21 Perry Street

Diapulse

The Medical and Scientific Committee of The Arthritis and Rheumatism Foundation states that the publicity being given to "Diapulse" as "a dramatic breakthrough in the treatment of arthritis" or "the best treatment of arthritis now available" is not in the best interest of the patients. It is the opinion of the committee that the evidence from clinical trials does *not* warrant these statements.

The value of a new treatment for arthritis cannot be based solely on early clinical experience. Such experience often leads to initial enthusiastic reports which may not be substantiated by later trials. This is especially the case in rheumatoid arthritis which has periods of natural, spontaneous remission during which the patient seems to improve no matter what is being done for him.

RONALD W. LAMONT-HAVERS, M.D.
Medical Director, The Arthritis and Rheumatism Foundation

Herpetic Neuralgia

Ethyl chloride spray was found effective in post-herpetic neuralgia. In a report in the *Lancet* (2:671, Sept. 24, 1960) Tavernor stated that intractable post-herpetic neuralgia was treated by brief interrupted spraying of the affected area with ethyl chloride. Of 16 patients 12 were free from pain for three to 21 months. Four failed to respond.

Skin was sprayed at a range of 24 inches for 60 seconds, taking care that the skin did not freeze. A coarse (general anesthetic) nozzle was used. A vigorous spray was essential. Once patients are familiar with the technic, they or their relatives are instructed how to continue it at home.

The patients included 6 men and 10 women 59 to 86 years old. Neuralgia was in the trunk in 9 and the head in 7; duration ranged from ten months to 13 years.

The spray technic is simple, harmless and satisfactory for home use. Freon® specially prepared was tried in 3 cases with good results. It is nonflammable, not a general anesthetic and not likely to freeze the skin.

Sol Browdy, M.D

Trenton

Obstetrical Aspects of Erythroblastosis Fetalis*

ABO incompatability accounts for more hemolytic disease of the newborn than Rh factors. Yet this aspect of obstetrical testing is often ignored.

This paper is presented primarily in the interests of our obstetrical colleagues, particularly those physicians who assume responsibility for newborn care. Its purpose is to re-emphasize some of the lesser publicized as well as basic concepts in the handling of cases of hemolytic disease of the newborn, to suggest more detailed prenatal testing, and to clarify misconceptions in the minds of some obstetricians.

PRENATAL TESTING

Much has been written, justifiably, of the time-honored routine of Rh testing of obstetrical patients prenatally. Yet, despite the documented statistical evidence that ABO incompatibility accounts for a much higher proportion of cases of hemolytic disease than Rh,[1,2,3] few references have appeared relating to prenatal determination of potentially affected ABO erythroblastotic infants.

It is true that ABO hemolytic disease is milder and practically never causes stillbirth or severe manifestations at birth in contradistinction to Rh erythroblastosis. Nevertheless, hyperbilirubinemia is a not uncommon accompaniment and until a better solution for the prevention of kernicterus is forthcoming, exchange transfusion is recommended whenever the serum bilirubin reaches 20 milligrams per cent.

Other differences between Rh and ABO hemolytic disease are worthy of repetition. At least 50 per cent of cases of ABO disease involve first-born children; but the outcome of successive pregnancies is highly variable and unpredictable. On the other hand, Rh erythroblastosis rarely affects the first offspring, but the disease usually becomes progressively severe in subsequent children.

Why shouldn't parents be forewarned in a tactful manner about prospective ABO as well as Rh incompatibility disease? Who has a better right to be told that because of differences in their major blood groups a child of theirs might develop excessive jaundice or anemia and require replacement transfusion in the first few days of life? It is better to hold such a discussion before delivery than to have a consulting pediatrician burst in upon the totally unprepared mother on the third or fourth day of life and inform her that her baby requires a replacement transfusion in order to prevent potential brain damage. Furthermore,

*Presented at the Annual All Day Clinic, Mercer Hospital Trenton, N. J. on October 26, 1961, in tribute to Dr. Wilbur C. Davison on the occasion of his retirement as Dean of Duke University School of Medicine.

1. Hsia, D. Y. and Gellis, S. S.: *Pediatrics*, 13:503 (1964).

2. Leikin, S. L., Rheingold, J. J. and Sites, J. G.: *Pediatrics*, 22:65 (1958).

3. Vaughn, V. C.: Hemolytic Disease of the Newborn Due to A or B incompatibility. (Unpublished data).

it is not inconceivable that the ugly spectre of malpractice, which has brought grief to many physicians in the form of Rh erythroblastosis, will ultimately invade the area of ABO disease.

In ABO hemolytic disease, the mother usually belongs to group O and the infant, to A or B. Just as the husbands of Rh negative mothers should have their Rh blood type determined, so should the husbands of group O mothers have their blood groups determined. Further attention should then be directed to those group O mothers whose husbands belong to group A, B or AB. Whereas anti-Rh titrations can be of value in following mothers sensitized to the Rh factor, the presence of immune anti-A or anti-B, especially as determined by the average hospital laboratory, is of unreliable significance and for practical purposes need not be determined.

Zuelzer and Kaplan[4] have shown that in the A x O incompatible matings only subgroup A_1 infants are affected, and Levine[5] suggests limiting the study to husbands of subgroup A_1, B, and AB. (Both A_2B as well as A_1B x O matings should be included because the former mating is incompatible for the B factor.)

At birth, the umbilical cord blood of the pre-selected cases should be tested for blood groups. Those of group O may be excluded. The remainder should then have further blood studies, including hemoglobin, bilirubin, nucleated red cell count and Coombs test, to serve as a guide for further observation, as in Rh cases. Levine has also pointed out the difficulty in differentiation of A_1 and A_2 bloods of the newborn, so that it would appear impractical to limit the study to A_1 fathers in the first place.

Certainly, attention to Rh negative mothers (whose husbands are Rh positive) and type O mothers (whose husbands are type A, B, and AB) will bring to light the vast majority of potential erythroblastotic infants. However, if the obstetrician also looks after the babies he delivers while in the hospital, he should at least be aware of some of the exceptional matings which, on rare occasions, can give rise to hemolytic disease.

To review: the Rh_0 (D) factor is found in about 85 per cent of the white (U.S.) population, and because of its clinical importance, the terms "Rh positive" and "Rh negative" are understood to refer solely to the presence or absence of this factor. Accordingly, the average laboratory when requested to determine the Rh type employs the anti-Rh (anti-D) serum exclusively. Actually, there are six basic related Rh factors: designated by Fisher and Race as D-d, C-c, and E-e; and by Wiener as Rh_0-Hr_0, rh′-hr′, and rh″-hr″. D(Rh_0) is involved in about 93 per cent of the cases of erythroblastosis due to Rh-Hr incompatibility.

When immunization of the Rh positive mother occurs—as it does occasionally—it usually involves the c(hr′) and/or E(rh″) factors.[6] Wiener, Wexler and Brancato[7] reported on nine cases of hr′ erythroblastosis, emphasizing the failure of routine antenatal management to detect sensitization to Rh-Hr factors other than Rh_0. They advocated the routine testing of the sera of all pregnant women, Rh positive as well as Rh negative, on admission to the labor room with special enzyme-treated (Papain or Ficin) test cells to detect most forms of Rh-Hr sensitization, especially hr′.

However, it would appear more logical and practical to include in the routine prenatal Rh determination of pregnant women testing for D, E, and c. If the patient is negative for any of these three factors, her husband should also be typed for them. Where any incompatibility is shown, consideration should be given to the determination of the respective titres, and a minimum work-up should include cord blood examination and appropriate follow-up observation. Parenthetically, it should be borne in mind that on occasion the husband will not have fathered the child and typing of his blood would be for naught.

4. Zuelzer, W. W. and Kaplan, E.: American Journal of Diseases of Children, 88:307 (1954).

5. Levine, P.: *Revue d'Hematologie,* 10:215 (1955).

6. The Rh Factor and Immunohematological Procedures. Ortho Pharmaceutical Corporation, Raritan, New Jersey, 1955. Page 7.

7. Wiener, A. S., Wexler, I. B. and Brancato, G. J.: Journal of Pediatrics, 49:381 (1956).

A case illustration of c sensitization will be summarized. This was the third child of a mother who had had two uneventful pregnancies, followed by a miscarriage at 4½ months involving twins. Since the mother's type was B Rh positive, no anti-Rh titre had been obtained and erythroblastosis was not suspected. The infant was born close to term without difficulty and presented a normal outward appearance. Jaundice was noted before 24 hours of age. Typing of the infant, performed on the second day of life, proved her to be type O D positive, c positive. Coombs test was positive. Initial capillary hemoglobin was 13.6 Grams. Initial serum bilirubin obtained was 13.7 milligrams per cent. Sixty-seven nucleated red cells were noted per hundred leucocytes.

Once the positive Coombs test was reported in conjunction with the infant's c positivity, a more complete typing of the mother revealed that she was type B D+ c-. On the third day of life the serum bilirubin rose to 21. Exchange tranfusion was done and the infant made an uneventful recovery. Ideally in these cases the donor blood should be c negative.

Although the vast majority of ABO incompatibility cases involve type O mothers, theoretically there are seven possible incompatible matings which can give rise to ABO erythroblastosis:

Father		Mother	Father		Mother	Father		Mother
B	x	A	A	x	O	A	x	B
AB	x	A	B	x	O	AB	x	B
			AB	x	O			

Levine[5] cites four cases affecting group B mothers, reported by Orozco *et al.*, Witebsky *et al.* and Dahr; and one case involving a group A mother, reported by Rosenfield.

The question arises whether an attempt should be made prenatally to identify potential ABO erythroblastotic infants of non-type O mothers. Admittedly, ABO hemolytic disease involving group A or B mothers is such a rarity that little would be gained by the purposeful search for their respective incompatible mates. However, if the conscientious obstetrician routinely obtained the blood group of the fathers as well as the mothers he could glance at the previous listing of incompatible matings and immediately spot potential trouble and act accordingly.

HEPATIC ENZYME DEFICIENCY HYPERBILIRUBINEMIA

IN THIS enlightened era of biochemical and enzymatic approach to disease it has become fashionable to regard so-called "physiologic jaundice" and its exaggerations as variable manifestations of hepatic enzyme deficiency in the newborn. Physiologic icterus is considered[8] to be caused by a temporary failure of the liver to conjugate (or detoxify) indirect bilirubin with glucuronic acid, the primary fault being transient inactivity of the glucuronyl transferase system. The variable duration and severity of this jaundice is felt to be related to the "normal variation" among infants in the activity of this enzyme system during the first week of life.

Boggs[9] is skeptical of the alleged relatively high incidence of ABO hemolytic disease because of the absence of a consistently positive confirmatory test such as the Coombs test in Rh cases. He has collected a series of unpublished cases[9] of neonates who developed hyperbilirubinemia in the absence of any demonstrable blood group incompatibility, whom he classifies as hyperbilirubinemia secondary to hepatic enzyme deficiency. Some infants who happen to have ABO incompatible parents (whose onset of jaundice occurs after the first 36-48 hours of life) might more properly be designated as cases of hepatic enzyme deficiency.

Whether we attribute this hyperbilirubinemia occurring irrespective of ABO incompatability to exaggerated physiologic jaundice or to hepatic enzyme deficiency is of academic interest only. What *is* important to the obstetrician is the awareness that hyperbilirubinemia can occur in the absence of demonstrable blood group incompatibility (and in the absence of a positive Coombs test); that the jaundice in these cases does not necessarily appear within the first 36 hours (and often occurs later); and that its intensity may not assume disturbing or alarming proportions until late on the third or fourth days. Obstetricians who are quick to promise their pa-

8. Yu, W. L. and Aldrich, R. A.: Pediatric Clinics of North America, 7:381 (1960).

9. Boggs, T. R., Jr. (Personal communication).

tients discharge on the third and fourth days should bear this in mind.

Although it is not the obstetrician's responsibility to direct therapy in these cases, it should be noted that exchange transfusion treatment for the control of this nonhemolytic hyperbilirubinemia of term or premature neonates has not gained the universal acceptance applied to cases of hemolytic jaundice. However, most authorities feel that any time the serum bilirubin reaches 20 milligrams per cent, regardless of the cause, exchange transfusion should be done. Day [10] has written an excellent comprehensive review of this controversial subject.

ERYTHROBLASTOTIC STILLBIRTHS

Erythroblastotic stillbirths are one of the most vexing and frustrating problems confronting the obstetrician and pediatrician. Premature induction of labor will not prevent erythroblastosis, but it can prevent some erythroblastotic stillbirths. The actual number of preventable stillbirths is limited by (1) the cold statistics of Vaughn [11] and Allen [12] that 70 per cent of stillbirths occur before the thirty-seventh week of gestation and 30 per cent after the thirty-seventh week, and (2) the uniformly poor results reported by Allen [13] and Abelson [14] when labor was induced before 35 to 37 weeks. Chown and Bowman [15] reported a successful outcome in seven highly selected pregnancies, each of which had been preceded by an average of two stillbirths. Labor was induced after 32 to 35 weeks of gestation, the time selected for delivery being based on the respective time of occurrence of the previous stillbirth. Two of the cases were delivered by Cesarean section.

Vaughn [16] suggests that focusing attention on the subjective impressions of the mother who is at high risk may help in the determination of the optimal time for her early delivery. Many of these women, he says, have a heightened sense of discomfort which is closely related in time to the rapidly developing serious illness of the fetus or impending intrauterine death. Symptoms include a feeling of unduly rapid enlargement, increased pressure and diminished fetal movement. Often there are objective findings of polyhydramnios.

What should be the responsibilities of the obstetrician in the prevention of stillbirths? Which patients should be considered candidates for early delivery? The zygosity of the husband is of prime importance and should be determined in every mating which has produced a stillbirth or hydropic infant. There is little disagreement in advising early delivery for the mother whose family is small, whose husband is homozygous and who has had a previous erythroblastotic stillbirth.

However, if the husband is heterozygous, there is a 50 per cent chance that a subsequent child will be Rh negative and therefore unaffected. Yet many of these heterozygous-fathered families are studded with stillbirths. The desirability of early interruption is highly controversial. Titres in these cases are notoriously unreliable and misleading. The utmost care and discretion must be exercised in making the ultimate decision, and the responsibility should be shared by the parents, obstetrician and pediatrician.

The double jeopardy in which the erythroblastotic infant is placed by induced prematurity cannot be overemphasized, particularly when delivery by Cesarean section with its added risk of the respiratory distress syndrome becomes necessary. From an obstetrical standpoint it is noteworthy that any dead fetus (whether erythroblastotic or not) when retained for two weeks, can give rise to hypofibrinogenemia in the mother with serious ante-

10. Day, R. L.: Pediatric Clinics of North America, 8:539 (1961).
11. Vaughn, V. C., Allen, F. H., Jr. and Diamond, L. K.: *Pediatrics*, 6:173 (1950).
12. Allen, F. H., Jr., Diamond, L. K. and Jones, A. R.: New England Journal of Medicine, 251:453 (1954).
13. Allen, F. H., Jr.: Quarterly Review of Pediatrics, 12:1 (1957).
14. Abelson, N. M.: Pediatric Clinics of North America, 1:541 (1954).
15. Chown, B. and Bowman, W. D.: Pediatric Clinics of North America, 5:279 (1958).
16. Vaughn, V. C.: Journal of Pediatrics, 54:586 (1959).

partum, intrapartum and postpartum hemorrhage. At times serial determinations of plasma fibrinogen may be indicated.

The foregoing discussion has dealt with the prevention of repeat stillbirths. Can the obstetrician do anything to prevent the first stillbirth in a family? Determination of titres has particular value in two specific situations. The first is the development of a relatively high titre in a first-affected pregnancy. Allen [12] and Abelson [14] feel that if a pregnancy involves a first-affected baby (the father being homozygous) and if the maternal titre is high (in their laboratories 1 to 64 or over), the chances of late stillbirth are great enough to warrant intervention at 37 weeks, if obstetric conditions are favorable for medical induction. Abelson [14] also feels that a precipitous decline in antibody titre often heralds a stillbirth or the beginning of polyhdramnios and merits consideration for early delivery.

LABORATORY EXAMINATIONS

THERE is no other disease entity where the attending physician is so dependent on laboratory data for diagnosis and guide to therapy as in hemolytic disease of the newborn. Yet, to accept reports glibly without correlating them with the clinical picture can be disastrous. Differences in reliability of the work of a regular staff of laboratory technicians compared with that done by less experienced night or holiday personnel should be appreciated.

Any physician who has ever managed a case of erythroblastosis fetalis can multiply case instances of the following nature, where ready acceptance of laboratory reports led to an unfortunate result. An Rh erythroblastotic infant with increasing clinical jaundice was being treated expectantly as the laboratory kept reporting (micro)bilirubin levels below 15 milligrams per cent. In order to spare infants (and attending physicians) frequent venipunctures the local laboratory had recently instituted a microbilirubin determination procedure. Finally, on the fourth day when the infant developed suspicious opisthotonus we did an exchange transfusion. The pre-exchange serum bilirubin specimen proved to be 27 milligrams per cent! Following the exchange, she appeared to improve clinically, but when last heard from was awaiting acceptance by a state school for mental defectives as a cerebral-palsied victim of the athetoid type secondary to kernicterus. We never order microbilirubins any more. This is not meant to disparage the value of accurate microbilirubins such as performed in laboratories of teaching institutions.

Recently, we followed an infant at another hospital who did not become jaundiced until the third day. There was no evidence of Rh or ABO incompatibility, and this was most likely a case of hepatic enzyme deficiency. Because of increasing moderate icterus late on the fourth day a serum bilirubin was ordered. The determination, done that night, was reported as 30 milligrams per cent. We rechecked the infant, who looked good and acted well except for the moderate jaundice, and ordered a repeat bilirubin level for early the next morning. It proved to be 16 milligrams per cent. Surely the report of 30, the night before was a laboratory error.

Certain laboratory examinations warrant further discussion:

(1) Some obstetricians lay undue emphasis on the significance of erythroblastemia by ordering "smear for erythroblasts" in suspected cases of hemolytic disease. Erythroblasts or nucleated red blood cells are usually increased in the peripheral blood of affected infants. But some who show no actual erythroblastemia come to require replacement transfusions. One of our "exchanged" babies never showed any erythroblasts on smear. On the other hand, erythroblastemia *per se* is not diagnostic of erythroblastosis fetalis. Other conditions which may give rise to erythroblastemia include intrapartum hemorrhage, maternal diabetes, generalized cytomegalic inclusion disease and syphilis.

(2) Most authorities agree that a cord hemoglobin level below 14 Grams per cent in affected infants is an indication for exchange tranfusion. Vaughn [16] writes: "It still appears not to be widely enough appreciated that after the opportunity to examine the hemoglobin level in cord blood is past, the hemoglobin level offers *no* help in the estimation of the need of the infant for exchange transfusion for the prevention of kernicterus."

We also urge an attitude of healthy skepticism towards low cord hemoglobin reports, especially in the absence of relatively pale skin or mucous membranes and other indications for exchange. Unless cord blood is promptly collected, immediately and thoroughly shaken in the oxalated specimen tube, and soon thereafter examined, the presence of gross and less discernible clots can greatly alter a true determination.

(3) The cord serum bilirubin level is probably a better single guide than the hemoglobin in determining the need for exchange transfusion. The normal average level of bilirubin in cord serum is less than 2 milligrams per cent. Wheeler and Ambuel [17] have shown that when the cord bilirubin exceeds 4, the future need for exchange transfusion to control an established or threatened level of serum bilirubin above 20 milligrams per cent will be found in 80 per cent of infants. On the other hand, when the cord bilirubin is less than 4, the need for exchange will occur in 20 per cent of affected infants.

One point worthy of mention is that the time-honored custom of "leaving the cord long" in suspected cases of hemolytic disease is no longer necessary. The first thing which most transfusionists do in an umbilical vein transfusion is to cut the cord to within a quarter or half inch of the abdominal skin margin to facilitate passage of a catheter or cannula.

17. Wheeler, W E. and Ambuel, J. P.: Pediatric Clinics of North America, 4:383 (1957).

SUMMARY

POINTS which are considered to be of special interest to the obstetrician in the management of hemolytic disease of the newborn have been discussed. A rationale and plea for broader prenatal testing is presented. Specifically, the suggestion is made to test mothers routinely for DEc and to determine the blood groups (A,B, O) of fathers as well as mothers. The concept of hepatic enzyme deficiency hyperbilirubinemia is briefly discussed. The problems surrounding the prevention of erythroblastotic stillbirths are reviewed. Determination of the father's zygosity and individualization of therapy is urged in every case. Finally, the chief laboratory criteria for performing exchange transfusions are enumerated along with sources of error in their determination.

434 Bellvue Avenue

Russian Medical Journals Available in Translation

The Library of the Academy of Medicine of New Jersey now offers translated versions of nine important Russian periodicals. Translation from the original is accomplished commercially through funds provided by the U. S. Public Health Service. The program was originally sponsored by the National Institutes of Health, as part of its Russian Scientific Translation Program. It is being continued by the National Library of Medicine in Washington, D. C.

Journals on the following subjects are included: biochemistry; biophysics; experimental biology and medicine; *The Pavlov Journal of Higher Nervous Activity;* hematology; blood transfusion; oncology; virology; microbiology, epidemiology and immunobiology; and the *Sechenov Physiological Journal of the USSR.*

They cover a time period ranging from 1956 to the present.

The Academy of Medicine of New Jersey Library, which is a collaborating Library in the program, is at 307 Belleville Avenue, Bloomfield.

Samuel C. Southard, M.D.

Ventnor City

Erythroblastosis Fetalis

A Severe Case Requiring Six Exchange Transfusions

Sometimes doctors discontinue transfusions in erythroblastosis because of persistent hyperbilirubinemia. This contribution stresses the need for giving as many exchange transfusions as are required to keep bilirubin below 20 milligrams per cent.

The purpose of this report is to emphasize the necessity of multiple exchange transfusion in combating the hyperbilirubinemia produced by iso-immunization. Exchange transfusion is the best therapy for hyperbilirubinemia. Until newer methods are available (which will differentiate patients who will develop kernicterus from a given level of bilirubin from those that will not develop kernicterus from the same level of bilirubin) an exchange transfusion should be performed *as often as necessary* to keep the serum bilirubin below a reading of 20 milligrams per cent in full term infants.

The following case report illustrates such an example of Rh iso-immunization where six exchange transfusions were required.

The mother and father, both Caucasian are each 28 years old. This was her second pregnancy. The first pregnancy resulted in a normal female infant slightly jaundiced the second day of life. She was type O, Rh positive. The Coombs test on the infant's blood was negative, the mother's blood showed no rise in antibody titer, the bilirubin rose to 7.4 mgms. per cent total and then decreased to normal. The mother has had no miscarriages and no previous conceptions. This is her only marriage. She has never received a blood transfusion, gamma globulin, auto-hemic therapy, or any injections of human products. Her blood test for syphilis was negative. She is in good health. Blood studies on the mother, father, and the second pregnancy, the patient of this report, are as follows:

	Blood Type	D	C	E	c	Rh
Father	O	+	O	+	+	Positive
Mother	B	O	O	O	+	Negative
Baby boy	B	+	+	O	+	Positive

The onset and first two trimesters of this second pregnancy were completely normal. A titer on the mother's blood in the second trimester was negative. There were no signs of any abnormality till one week before delivery, at which time the mother noticed a marked decrease in fetal movements. At this point her serum contained anti-D albumen agglutinins to a titer of 1 to 64.

At birth the baby was pale, listless, and apneic. The infant was immediately resuscitated by the obstetrician and given oxygen. When spontaneous breathing started the child was placed in an isolette with oxygen and more thoroughly examined. Physical examination revealed the baby to be mottled, icteric, listless and limp. The liver was palpable three centimeters below the right costal margin. The spleen was palpable four centimeters below the left costal margin. Fine crepitant rales were heard at both bases. The eyelids and dorsum of the hands were edematous. The heart rate was 110 per minute. The weight at birth was seven pounds, three ounces.

Cord blood hemoglobin was 4.5 Grams. Hematocrit was 19. The baby was blood group B Rh positive, little c positive. The Direct Coombs test was strongly positive. The bilirubin on cord blood was: one minute—2.7 mgms. per cent, total—8.6 mgms. per cent. A diagnosis of erythroblastosis fetalis was made and immediate arrangements were made for replacement transfusion.

The baby's main problem at this point was anemia with increased venous pressure, as evidenced by the rales at the bases of the lungs and the minimal edema present. Since the heart rate was 110, it was felt that there was no cardiac decom-

pensation. For this reason we elected to conduct the first exchange using partly packed type B, Rh negative blood which was Coombs cross-matched with the mother and baby. We drew off one-third of the plasma.

Technic: Here is the technic we used on all the exchanges. The baby was restrained on a circumcision Y board, external heat was applied and continuous oxygen was administered by the anesthetist. The abdomen was prepared and draped in the usual manner for surgical operation. The circulating nurse acted as score keeper and announced the completion of each 100 cubic centimeters of exchange. The umbilical vein was cannulated with a K 32 sterile feeding tube.* The tube was prepared in the following manner: the plastic plug which is attached to the hub of the tube was clipped off so as not to be in the way; the end of the tube was cut with scissors five centimeters distal to the black mark which is put on the tube by the manufacturer. On passing the tube through the umbilical vein a reflux of blood was obtained when the end of the tube entered the circulating blood. The first step was to measure the baby's venous pressure. The exchange then was conducted by first producing a deficit and then giving and withdrawing 20 cubic centimeter portions of blood. The tubing and syringes were rinsed with heparin solution and the baby was given a cubic centimeter of 10 per cent calcium gluconate per 100 cubic centimeters of exchange. Venous pressure was taken frequently by the operator. The apical pulse and respirations were followed serially by the anesthetist. A closed system was used by attaching two two-way stop cocks serially to the end of a 20 cubic centimeter syringe. The administrating end of the second stop cock was attached to the K 32 tube,* the lateral hub of the second stop cock had sterile tubing on it which led to a sterile waste basin for the discharge of blood and the lateral hub of the first stop cock was attached to the bottle of blood with sterile tubing. When calcium was to be given the discharge rubber tubing was disconnected from the lateral hub of the second stop cock and the syringe containing 10 per cent calcium gluconate solution was attached. The calcium solution was then drawn into the system and then the next quota of blood drawn into the 20 cubic centimeter syringe so that the one cubic centimeter of calcium gluconate would be mixed with the next 20 cubic centimeters of blood due to be given. This method decreased the rate of administration of the calcium. It has been our experience that this appreciably diminishes the slowing of the heart which is sometimes evident if the calcium gluconate is injected separately.

The Six Tranfusions: The venous pressure at the onset of the first exchange was 10 centimeters, thus confirming our impression of increased intravascular volume with increased venous pressure. For this first exchange, 660 cubic centimeters of blood were taken out and 630 cubic centimeters of blood given, thus leaving a deficit of 30 cubic centimeters which was necessary to reduce the baby's venous pressure. The venous pressure at the end of the procedure was 5 centimeters. At the completion of this first exchange the hemoglobin was 12 Grams, and the red count was 3,930,000; there were 75 nucleated red blood cells, the bilirubin was 1.8 mgms. per cent for 1 minute and 8.2 mgms. per cent total. The bilirubin and blood count were followed every three hours. At nine o'clock that night, the baby was thirteen hours of age; the hemoglobin was 14.5 Grams; the red count was 5,020,000; the one minute bilirubin was 3.6 mgms. per cent, and the total 13.3 mgms. per cent. Serial determinations were continued.

After the first exchange there was a remarkable improvement in the baby's general status. The rales disappeared from the chest, the edema disappeared from the eyelids and back of the hands, the color was better, the baby was more active and vigorous. He had been continued in the isolette with two liters of oxygen and prophylactic antibiotics consisting of procaine penicillin, 100,000 units, and streptomycin 40 milligrams intramuscularly every 12 hours. He was given KEC drops® 0.6 cubic centimeters daily.†

By the next morning, when the baby was 24 hours old, the one minute bilirubin was 5.7 mgms. per cent and the total 21 mgms. per cent. Hemoglobin had dropped to 10.3 Grams and the erythrocytes to 3,860,000, the nucleated red cells had risen to 382 per 100 white blood cells.

Accordingly, with this bilirubin of 21 a second exchange was done at 26 hours of age on April 17, 1960. This exchange again used type B, Rh negative blood, Coombs crossed with mother and infant, but whole blood was used instead of partially packed cells. The venous pressure at the onset of the procedure was 7 centimeters and at the end of the procedure was 6 centimeters. The totals out were 550 cubic centimeters; totals in 500; leaving a deficit of 50 cubic centimeters which was necessary to keep the venous pressure beneath 7 centimeters. At the completion of this second exchange, the total bilirubin was 12.4 mgms. per cent and the one minute bilirubin 2.5 mgms. per cent, the hemoglobin was 8.2 Grams, the red blood count 2,850,000. These studies were followed serially for the rest of the day. By eight o'clock that night of April 17, at 36 hours of age, the one minute bilirubin was 5.6, the total 19.4, the hemoglobin was down to 6.2 Grams, platelets 48,000. The alkaline phosphatase was 6 Bodansky units, and transaminase tests were—SGOT 160 units, SGPT 25 units. At this point with the bilirubin rising one milligram per hour, it was elected to do the third exchange. The baby was intensely icteric and had a purplish mottling which did not blanch with digital pressure. There was also a grade 2 systolic murmur heard at the apical area.

The third exchange was done on April 17, thus making two exchanges on that day. This exchange transfusion was conducted using type B, Rh negative blood, Coombs crossed with mother and baby, blood having been freshly drawn two hours before use. Venous pressure at the onset was 75 millimeters; venous pressure at the end was 65 millimeters. Totals consisted of 590 cubic centi-

*Manufactured by the Pharmaseal Company of Glenside, California.

†K.E.C. is a Hoffmann-LaRoche tradename. Generic name was not given by the author.

meters out and 580 cubic centimeters in, leaving a deficit of 10 cubic centimeters. The bilirubin at the end of this procedure was 2.5 mgms. per cent one minute, 10.7 mgms. per cent total. The red cells were 4.6 million, hemoglobin 10.3 Grams. These were recorded at eleven p.m. in the evening of April 17, 1960.

The next morning, April 18, 1960, the total bilirubin was up to 18.0 mgms. per cent, one minute being up to 3.0 mgms. per cent, the hemoglobin was 11.4 Grams, red blood count 4,459,000. By 6:30 that evening the one minute was 7.7 mgms. per cent and the total 23 mgms. per cent, red blood count and hemoglobin had not changed. Accordingly, it was felt that a fourth exchange was indicated. The baby's clinical status was somewhat improved, he was much more vigorous, the mottling had decreased, the heart sounds had been normal at the completion of the third exchange, but by the time the fourth exchange became indicated the murmur was again heard. The liver and spleen, which shrank appreciably with each previous exchange transfusion increased in size as the day went on and both were down approximately 4 centimeters. The chest was clear and there was no edema. The fourth exchange was done on the evening of April 18, 1960, again using fresh type B, Rh negative blood properly crossmatched. The total in was 530 cubic centimeters, total out 560 cubic centimeters, which deficit of 30 cubic centimeters was necessary to keep the venous pressure the same as at the onset of the procedure. At the end of this, the fourth exchange, the one minute bilirubin was 3.3 mgms. per cent and the total bilirubin 11.8 mgms. per cent. The RBC and hemoglobin remained at about the same levels, that is 10.7 hemoglobin and 3.49 million red blood count. The baby's therapy consisted of oxygen in the isolette, KEC®† drops, the streptomycin was discontinued after 48 hours and replaced with chloramphenicol. The penicillin was continued. Feedings of sugar water were ordered every two hours beginning at 36 hours of age and then alternate feedings of sugar water and Alacta®* were ordered at 48 hours of age. Serial blood studies were continued.

By the morning of April 19, 1960 the one minute bilirubin was up to 9.0 mgms. per cent and the total 22.3 mgms. per cent. A urinalysis for inclusion bodies of cytomegalic inclusion disease was negative. At this point steroid therapy was started using prednisolone 5 mgms. intramuscularly every 12 hours. On the first day a sample of blood of the mother and the baby had been sent to the Ortho Research Foundation under the direction of Dr. Philip Levine. On this morning, just prior to the fifth exchange, they completed their studies and confirmed our serologic findings. With a bilirubin of 22.3 total it was felt that a fifth exchange was indicated. This was done using the same type blood prepared in the same fashion and the totals consisted of 600 cubic centimeters out, 585 cubic centimeters in, leaving a deficit of 15 cubic centimeters. The venous pressure at the onset was 75 millimeters and at the end of the procedure was 70 millimeters. At the completion of this procedure the SGOT was 35 units and the SGPT was 18 units. The bilirubin one minute was 3.1 mgms. per cent, total 8.6 mgms. per cent, red blood count 2.86 million and hemoglobin 8.0 Grams. Serial blood studies were continued.

By one o'clock in the afternoon of the next day, April 20, 1960, the bilirubin had risen to a total of 20 mgms. per cent, the one minute being 9.7 mgms. per cent, this constituted a rise of 11.4 mgms. total bilirubin in 24½ hours, or approximately one-half milligram (per hour). Accordingly, on April 20, a sixth exchange was done using the same type blood prepared in the usual fashion. This time the totals consisted of 585 cubic centimeters out and 575 cubic centimeters in with a deficit of 10 cubic centimeters. The venous pressure at the onset was 70 millimeters and the venous pressure at the end 65 millimeters. At the completion of this sixth exchange the hemoglobin was 8.3 Grams, red blood count 2.74 million, and the bilirubin total 6.7 mgms. per cent.

Twenty-four hours later on April 21, 1960 the one minute bilirubin was 7.4 mgms. per cent, the total 13.6 mgms. per cent, thus constituting a rise of only 7 mgms. in 24 hours. Serial studies were continued and by the next day, April 22, the bilirubin had fallen, the total being down to 10 mgms. per cent, the one minute remained high for several more days and then gradually began to decrease so that on April 24, the one minute was 5.9 and the total 11.3. After the sixth exchange the bilirubin never rose above the 13.6 previously mentioned. By April 27, 1960 the one minute was 3.5 mgms. per cent, the total 6.09 mgms. per cent and these gradually decreased to normal.

During these fitful days of replacement transfusions the baby's neurologic examination remained normal. There were normal Moro reflex, crossed extension, sucking, rooting, and walking reflexes. At no time was there opisthotonos or a reversed Moro reflex.

Course: After the sixth exchange transfusion, the antibiotic and steroid therapy were continued for several days until it was evident that a seventh exchange would not be required. At this point these medications were gradually decreased. By this time the child's formula of Alacta®* was increased to the normal caloric content for age. The baby had been gradually weaned off the oxygen in the isolette and then transferred to a heated crib. On April 30, 1960, ten days after the completion of the sixth exchange, the baby was noticed to be trembling but not convulsing. There was no Chovstek reflex nor carpopedal spasm, but there were trembling movements of the eyelids and extremities, more than would be considered normal. At this point, calcium was 10.6 mgms. per cent and phosphorus 8.9 mgms. per cent. We interpreted this as a relative hypocalcemia, consequently the baby was started on calcium lactate by mouth. Along with this the trembling decreased. During the two weeks after the sixth exchange two small transfusions were indicated to bring the hemoglobin and red count up to near normal levels. The

*Alacta® is a Mead-Johnson tradename. Similac® is a formula developed and tradenamed by Ross Laboratories of Columbus, Ohio. Poly-Vi-Sol® and Fer-In-Sol® are also Mead-Johnson tradenames.

child was discharged on May 9, 1960 with a completely normal physical examination and a hemoglobin of 11.4 Grams and a red count of 3.727 million.

Subsequent History: After discharge from the hospital the baby was followed frequently at home. By May 20, 1960 his weight had increased to seven pounds, thirteen ounces. His blood showed 8.5 Grams of hemoglobin and 4.5 million erythrocytes with reticulocyte response of 3.1 per cent. He was eating well but very slowly and his formula had been changed from Alacta®* to Similac®* with iron, in addition he was given Poly-Vi-Sol®* and Fer-In-Sol®* drops, 0.6 cubic centimeters, twice a day. Neurologic examination revealed a normal Moro response and normal walking, rooting, grasp, and eye-following reflexes. The only abnormalities were the trembling previously mentioned, which had considerably increased; also when held erect to check the walking reflex the trunk was held rigidly. Consequently, oral calcium lactate was restarted.

On June 2, 1960 the blood count had fallen to 7.5 Grams of hemoglobin and 2.52 million red cells; also there was significant decrease in the reticulocyte response which had been followed every three to four days since discharge from the hospital—this had dropped down to 0.2 per cent. On June 3, 1960 he was given a simple transfusion, indirect type, of 83 cubic centimeters of blood. This brought his hemoglobin up to 11.4 Grams and the red cells to 3.8 million. Two weeks later his blood count had not dropped as rapidly as it previously did. The hemoglobin was 9.6 Grams, the erythrocyte count was 3.3 million, and the reticulocyte 0.4 per cent. He was slow in feeding and still had some trembling motions of the arms and legs. When held erect on eliciting the walking reflex he held his trunk rigidly. However, the Moro reflex, walking reflex, stepping reflex, grasp reflex, crossed extension, sucking, and rooting reflexes were all normal.

By July 1960 he was maintaining a blood count relatively the same as last reported and the rigidity and trembling had diminished.

By August 1960 he was beginning to make more red blood cells than he was destroying. His red blood count being 3.7 million, hemoglobin 10 Grams, reticulocyte 1 per cent. There was a gradual disappearance of the trembling motions and the rigidity of the body.

By September 1960 physical examination was completely normal. He cooed back when cooed at; he watched his hands and feet; followed with his eyes; turned over, reached for toys and playthings; and tried to sit up. Neurologic examination was completely normal.

By December 1, 1960 his weight was sixteen pounds, six ounces, height 28 inches, head 18 inches, chest 18 inches. Examination was completely normal. His hemoglobin was 12.5 Grams; red cells were 4,200,000; leucocytes were 12,950; Polys—12 per cent, Lymphs—87 per cent; Monos—1 per cent; Reticulocyte—0.4 per cent. At this point we had a consultation with a neurologist who found no evidence of any abnormality. He has remained normal to the date of this writing, October 15, 1961.

SUMMARY

A DETAILED case report of a severe case of erythroblastosis fetalis has been presented. This infant required six exchange transfusions to control the level of the bilirubin. Until newer methods for controlling hyperbilirubinemia are developed repeat exchange transfusions must be done *pro re nata* to keep the bilirubin below 20 milligrams per cent in full size, full term infants, involved with isoimmunization.

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The author wishes to thank Dr. Philip Levine of the Ortho Research Foundation of Raritan, New Jersey, and his staff, especially Miss Marjorie Stroop, for their valuable assistance in managing this patient.

Adoptions Up

The number of children adopted each year during the past ten years has increased 34 per cent according to *Patterns of Disease*, a Parke, Davis & Company publication for the medical profession. Among the reasons cited is the growing acceptance of adoption as a means of establishing a family.

Sol J. Fanburg, M.D.

Newark

Dexamethasone* in the Dermatoses

A methylated synthetic analogue of prednisolone (dexamethasone) has effected favorable results in 77 per cent of the dermatologic patients on whom it has been reported.

Because of their pronounced anti-inflammatory activity, synthetic glucocorticoids have become uniquely important in the allergic and inflammatory dermatoses. Although their effectiveness is beyond doubt, administration of oral steroids is not without some hazard; therefore, it is accepted practice to reserve these agents for short-term treatment of dermatoses which do not respond to topical preparations or other conservative measures.

Heightening the anti-inflammatory potency of the steroids would not have practical significance unless undesired metabolic activity was decreased or at least not proportionately increased. It is unlikely that these effects are completely separable but there has been some success in the attempt to raise the therapeutic index of these agents through a relative dissociation of desired and undesired activity. Dexamethasone,* a methylated synthetic analogue of prednisolone with five to 30 times the milligram potency of older analogues, has aroused considerable interest because clinical and metabolic studies [1-5] indicate that the doses which provoke an optimal anti-inflammatory response have little or no effect on glucose metabolism or electrolyte balance.

METHOD

Dexamethasone* was used to treat acute and chronic dermatoses in 11 males and 24 females. The series includes three children (four, seven, and 12 years); the adults were between 16 and 69 years. The dosage, for acute conditions, of three tablets (2.25 milligrams total) daily usually was discontinued within one week or reduced to two, one, and then one-half tablet daily. Because of the anticipated longer duration of therapy, patients with chronic dermatoses were treated with one (0.75 milligram) or two tablets daily, reduced as soon as possible to one or one-half tablet daily or on alternate days. Most patients with acute conditions were treated for only one or two weeks; in chronic conditions the duration of treatment ranged between three and eight weeks. Four patients had previously received other steroids topically or orally and four with allergic dermatoses had been treated with antihistaminic agents. Dexamethasone* was substituted in these patients because the response to previous therapy was considered inadequate.

*Dexamethasone as Deronil® was provided for this clinical trial by G. Kenneth Hawkins, M.D., of the Medical Research Division, Schering Corporation, Bloomfield, N. J.

1. Boland, E. W.: California Medicine, 88:417 (June 1958).

2. Boland, E. W.: Annals of Rheumatic Disease, 17:376 (December 1958).

3. Bunim, J. J. *et al.*: Arthritis and Rheumatism, 1:313 (August 1958).

4. Bunim, J. J.: Inter-American Archives of Rheumatology, 1:464 (September 1958).

5. Slater, J. D. *et al.*: Lancet, 1:173 (January 24, 1959).

RESULTS

Most of our patients responded very well to dexamethasone.* Acute dermatoses usually were completely relieved within one week and pruritus diminished on the first or second day of treatment. The drug was discontinued after brief therapy and symptoms did not recur.

Dexamethasone* also relieved the pruritus and inflammation of chronic dermatoses and seemed to prevent development of new lesions. Low maintenance doses, usually one tablet daily, kept chronic inflammatory skin diseases under good symptomatic control. As little as one-half tablet daily or on alternate days was sufficient to control pruritus. If the drug was stopped entirely there usually was an exacerbation of the disease. This occurred in six patients with chronic dermatitis or eczema, in two patients with lichen planus, and in a patient with psoriasis. Resumption of therapy again provoked remissions in these patients.

Total Patients	Diagnosis	Good Result	Fair Result	Poor Result
1	Dermatitis herpetiformis	1	0	0
12	Dermatitis venenata	12	0	0
1	Eczema	1	0	0
3	Eczema, allergic	3	0	0
3	Eczema nummulare	3	0	0
1	Eczema papulosum	1	0	0
1	Herpes zoster	0	0	1
2	Lichen planus	2	0	0
2	Neurodermatitis	2	0	0
1	Pemphigus	1	0	0
1	Pityriasis rosea	1	0	0
3	Psoriasis	2	1	0
4	Urticaria	3	0	1
35	Totals	32	1	2

SIDE EFFECTS

Five patients reported side effects. During administration of three tablets (2.25 milligrams) daily, one adult complained of "heartburn" and another (with a history of peptic ulcer) experienced epigastric pain; the drug was discontinued in both patients. A 33-year old woman gained some weight and showed slight "moon facies" on three tablets daily but it was not necessary to withdraw the drug prematurely. On doses of one-half tablet daily, another woman complained of numbness in the leg and a third female reported backache. The latter interrupted therapy but was able to resume dosage without recurrence of the backache. It seems unlikely that this extremely low dose of dexamethasone* could have provoked the symptoms in these two patients.

COMMENT

Generally similar results were obtained by other investigators who had used 3.0 milligrams daily or less of dexamethasone* to treat allergic, acute, and chronic dermatoses. A satisfactory response occurred in 40 of 57 patients reported by Grayson and Shair,[6] in 18 of 20 patients reported by Kohn and Grater,[7] in 60 of 76 patients reported by Lackenbacher,[8] in eight of nine patients reported by Parish,[9] and in 15 of 17 patients reported by Rudolph.[10] Including our own results (satisfactory in 32 of 35 patients) the consolidated experience shows that 77 per cent of 214 patients with dermatoses responded favorably to dexamethasone.* In general, the best results occurred in acute and allergic dermatoses, and the poorest in psoriasis and herpes zoster.

The side effects of dexamethasone* are not serious. Increased appetite, and consequent gain in weight, is not uncommon. Gastro-intestinal distress may also occur but this apparently is not related to production or exacerbation of peptic ulcers. Slight "nervousness," euphoria, and insomnia have been reported. Very rarely,

6. Grayson, L. and Shair, H.: GP, 22:9 (May 1959).

7. Kohn, C. M. and Grater, W. C.: *Allergy*, 17:385 (June 1959).

8. Lackenbacher, R. S.: Medical Times, 87:1629 (December 1959).

9. Parish, F. A.: Annals of Allergy, 17:701 (October 1959).

10. Rudolph, J. A. and Rudolph, B. M.: Annals of Allergy, 17:710 (October 1959).

mild Cushing syndrome-like symptoms (including "moon facies") or a mineralocorticoid effect (fluid retention) occurs but the incidence is so slight as to be insignificant. Serious side effects which have been observed with other corticosteroids are unlikely with dexamethasone,* especially if the daily and cumulative dosage is kept at the minimal effective level. The absolute and relative contra-indications to therapy with glucocorticoids apply also to dexamethasone.*

SUMMARY AND CONCLUSIONS

Dexamethasone* (Deronil®) was used to treat acute or chronic dermatoses in 35 patients. On daily doses of 2.25 to 0.75 milligrams, 32 patients had a good response, one patient had a fair response, and two patients were withdrawn from therapy because of side effects. Dexamethasone* rapidly relieved pruritus and acute dermatoses; low doses provided satisfactory maintenance therapy for chronic inflammatory skin diseases.

31 Lincoln Park

Office Dermatology

The efficacy of ambulatory management of ten common dermatoses in 1947 and in 1957 was compared. Criteria of efficacy were the number of office visits and the total time needed for control of the dermatoses. Twenty relatively comparable patients out of 251 in each diagnostic category in 1947 and out of 260 patients in 1957 were considered. For the entire group, 1.5 fewer office visits and 11.5 days less of total treatment time were required for cure or control of the 1957 group in comparison with the 1947 group. In dermatoses known to be hypersensitivity reactions, the differences in necessary treatment times and office observations were considerably greater (2.2 fewer observations and 19 days less of total treatment). The differences were statistically significant. In large measure, the increased efficacy of 1957 dermatologic treatment has resulted from the steroid medications.—A. L. Weiner, M.D.—Archives of Derm., 82:163 (1960).

Depilatory Wax

A simple depilatory wax for the removal of excess hair from the face can be made from two-thirds resin and one-third beeswax, reports Veronica L. Conley of the A.M.A. Committee on Cosmetics, in the September 17, 1960 issue of the *Journal of the American Medical Association*. This material is applied in the liquid state with a spatula or a brush "in a smooth layer along the same direction as the hairs. The wax will set at body temperature.

"While the wax is cooling, a small corner can be loosened and raised. When the wax is cold and hard, it can be grasped at this point and pulled away against the direction of the growth of hair. If the preparation has been properly compounded, it will come away in one piece holding all the hairs firmly imbedded," the A.M.A. consultant explained.

If the preparation in the suggested ratio is too brittle, the proportion of beeswax may be increased, Dr. Conley added.

Ronald Altman, M.D.*

Trenton

Period of Infectiousness of Infectious Hepatitis

A Review of the Literature

Special precautions against transmission of hepatitis may be relaxed if three weeks have elapsed after onset of the illness, if the patient is obviously convalescing. Precautions should continue if the patient remains sick.

The period of infectiousness of infectious hepatitis (hepatitis A) has been the topic of many investigations over the past two decades. The usual method of spread is thought to be the fecal-oral route, although it is recognized that parenteral transmission occurs through the use of blood, blood products and improperly sterilized equipment. Spread from nasopharyngeal secretions and urine has been postulated but the evidence for this is contradictory. Most authorities do not now accept spread *via* these routes as a usual method of transmission of infectious hepatitis.[2] Hence, most attention has been directed to the elucidation of the period when the virus might be found in the blood or in the stool in a case of infectious hepatitis.

There is no generally accepted laboratory method for the detection of the virus of infectious hepatitis. Hence, all studies for the presence of virus in a specific material being tested must be done on human volunteers. The criterion used to establish the virus is the development of clinical hepatitis in the volunteer. The diagnosis is generally made without too much difficulty when the subject develops jaundice; but it may be difficult to decide whether a volunteer has hepatitis when he develops a mild anicteric illness. Liver function studies, particularly serum transaminase determinations, are useful, but do not always provide a final answer. Also, many of the volunteer studies (cited below) were done before the time of general use of serum transaminase determinations; liver function tests may be less sensitive in the anicteric cases in such a situation. All these studies are sharply limited by the number of volunteers available and, therefore, in the amount of material that could be tested.

The virus of infectious hepatitis is in the stools and blood during the acute phase and the pre-icteric phase of the disease.[2] The virus is also believed to be present during the incubation period of the disease. The time of its usual appearance in the stool and blood has been the subject of conflicting reports. In most experiments, virus has *not* been found during the convalescent stage, but there have been exceptions.

Havens[4] showed that serum and stools obtained four to five days after the onset of illness and one to two days before the onset of

*Epidemic Intelligence Service Officer, Communicable Disease Center, United States Public Health Service assigned to the Division of Preventable Diseases, New Jersey State Department of Health.

jaundice produced infection in five of nine volunteers. He also found[4] that pooled acute phase serum and stools from five cases of hepatitis produced hepatitis in five of six volunteers, although urine and nasopharyngeal secretions taken from the same patients at the same time failed to give disease. Paul, et al.[10] reported that in four of five volunteers, serum taken during the pre-icteric stage was infectious when ingested orally. In six of 11 volunteers, it was infectious when given parenterally. Stool, when taken in the acute phase of the disease, was found to be infectious in two of three volunteers. Many other investigations have shown stool and blood to carry infectious hepatitis virus during the acute phase of the disease.

NUMEROUS works show the virus of infectious hepatitis in the blood and stools during the incubation of the disease. Francis, *et al.*[3] described a group of circumstances which showed that the virus of infectious hepatitis was in the blood at least three days prior to the onset of illness. In this situation, a blood donor became ill with hepatitis one day after the donation. Within 5 days he was dead of his disease. The recipient of the transfusion developed abdominal symptoms 11 days after receiving the transfusion. He developed jaundice ten days later (21 days after receipt of the blood). He eventually recovered. Serum was obtained from this patient eight days after transfusion (three days before symptoms and 13 days before jaundice). This serum was given to four volunteers. Three of the four developed hepatitis with incubation periods of 35, 38, and 38 days. Of these volunteers, one died of the disease, one had a prolonged course, and one had a mild illness.

Havens and Paul[6] state that, in the incubation period, the virus is found in the feces.

Havens[4] reported an experiment in which virus could *not* be found in serum taken midway in the incubation period. A volunteer who developed hepatitis after a 26-day incubation period was bled 13 days after ingesting the virus. The serum from this bleeding was not infectious in three other volunteers.

Extensive studies on the presence of virus in the feces and blood were done by the group at the Willowbrook State School in New York. Ward, *et al.*[13] described an experiment there on stools collected from subjects who developed jaundice 39, 41 and 46 days after ingestion of infectious material. The stool was collected 25 days after feeding. It was pooled, treated, and fed to 13 subjects. Two of these 13 subjects developed hepatitis with jaundice. Thus, the feces were infectious two to three weeks before the onset of jaundice.

Krugman, *et al.*[7] described a similar experiment on serum taken from three subjects who became icteric, 41, 44 and 49 days after virus feeding. The serum was taken 25 days after the feeding (16 to 24 days before the onset of jaundice). The serum was administered to 12 subjects, six of whom developed hepatitis with jaundice after incubation periods of 47 to 60 days. Thus, viremia was present three weeks before the onset of jaundice. At this time, all the liver function studies, including serum transaminase, were negative on the subjects from whom the icterogenic serum was taken.

As a result of these experiments, Ward, *et al.*,[12] stated that virus is present in the blood and stool two to three weeks prior to the development of jaundice. Eichenwald and Mosley[2] also say that virus is present in the blood at least two weeks prior to the onset of symptoms.

PRESENCE of the virus of infectious hepatitis in the feces and blood in the convalescent phase is a matter of more controversy. Most authorities agree that virus is not found in the blood or stools during the convalescent stage; but there are a few studies which show chronic carriers.

Havens[4] found that serum and stools obtained 25 to 31 days after the onset of disease did *not* produce disease, neither when given from individual patients nor when given as a pool. Opinions[2,5,6] in reviews on this subject generally support the findings that the

virus disappears from the blood and stools within two to three weeks after the onset of disease.

However, studies which show exceptions are also cited. The most notable were those described by Capps and Stokes[1] and by Stokes, *et al.*[11] These authors report two orphanage children with chronic hepatitis. One, aged 28 months, had persistent symptoms and abnormal laboratory findings five months after the onset of disease. Stools taken at this time produced hepatitis in one of four volunteers, to whom it was fed, after an incubation period of 22 days. The second child, 11 months old at the onset of illness, continued to show intermittent symptoms and abnormal laboratory tests for 15 months, at which time stools were collected and fed to four volunteers. One of these volunteers developed hepatitis after an incubation period of 26 days. Thus, there was fecal excretion of hepatitis virus five and 15 months after the onset of disease. However, it must be remembered that both of these children were chronically ill.

AN INTERESTING experiment was described by Neefe, *et al.*[9] Long after the onset of illness, material was collected from three subjects with hepatitis. Feces and serum were collected 120 to 400 days after the onset of illness. Liver tissue was obtained by biopsy on two of the patients 230 and 270 days after on et. Three of five volunteers who ingested the stools had a mild illness 18 to 20 days after ingestion. Four of the five volunteers who ingested liver suspension became ill 15 to 36 days after ingestion. None of the five volunteers who received serum became ill. The symptoms shown by the volunteers who became ill were malaise, headache, anorexia, nausea, vomiting, abdominal cramps, and pain in the right upper quadrant. Two subjects had liver tenderness and one had a moderately enlarged liver. None of the volunteers developed jaundice, and there were no abnormal laboratory tests. (This work was published in 1947 before the use of serum transaminase determinations as a liver function test.) It is a matter of speculation whether these volunteers had hepatitis.

Thus, it appears that there are chronic fecal carriers of hepatitis, but the only really proved fecal carriers have been patients with persistent symptoms. Most patients with hepatitis probably will cease to excrete virus in two or three weeks after onset.

In considering the problem of fecal excretion of the virus of infectious hepatitis from the public health standpoint, the role of the patient without apparent infection is important, if not more important than the apparent case. Krugman, *et al.*[7] showed that a patient with *inapparent* infection had viremia. The subject was involved in the experiments at Willowbrook. He was fed infectious material and was followed for 66 days, in which time he did not manifest signs of illness. He was followed with serial liver function studies. All liver function tests were normal except the serum transaminase which reached its highest level of 250 units in 37 days after ingestion of a fecal suspension. Serum taken on the 37th day was given to eight subjects intramuscularly. Three of these eight subjects developed hepatitis with jaundice after incubation periods of 40, 47 and 48 days. Hepatitis without jaundice developed in another three of these eight subjects after incubation periods of 33, 37 and 47 days. While this experiment only proved viremia in an inapparent infection, viremia and virus in stool seem to be paralleled in most experiments on infectious hepatitis. It is reasonable to assume that virus is excreted in the stool at some time during an inapparent infection. Krugman, *et al.*[8] have hypothesized that there are 12 *inapparent* cases to every *clinical* case. This figure has not been accepted by many workers; but most investigators feel that there are many inapparent infections with the virus of infectious hepatitis. These inapparent infections are probably a large source of the spread of infectious hepatitis.

SUMMARY

THE virus of infectious hepatitis is found in the blood and stool of patients in the acute stage of the disease. Virus is also present during the incubation period. How long in the

incubation period of each individual case virus is present in the blood and stool is a matter of speculation. It is probable that in cases with a long incubation period, virus is present in the blood and stool two to three weeks prior to the onset of illness. In the convalescent period, most patients will cease to have detectable viremia or excrete virus in the feces after the third week following the onset of disease, although a few patients will continue to excrete virus. It is significant, however, that in the proved cases of long excretors of virus the patients were chronically ill with hepatitis.

It would seem from these studies that, providing about three weeks have elapsed after the onset of the disease, special precautions could be relaxed after the acute stage has passed and the patient is convalescing. However, in patients who continue to show signs of illness with hepatitis, special precautions should continue. Finally, in considering control measures for infectious hepatitis, one must remember that *inapparent* infections probably constitute a very large source of transmission of the virus.

The State Department of Health

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Foreign Drugs for Soldiers and Veterans

The Military Medical Supply Agency and the Veterans Administration have sent millions of the taxpayers' dollars overseas to purchase cheap, pirated versions of powerful drugs discovered by U. S. companies and presumably protected by U. S. patents. This practice was deservedly denounced by American labor when the Oil, Chemical, Atomic Workers International Union passed a resolution strongly condemning it. When the government goes shopping, the taxpayer has a right to expect that it will spend his money wisely, for a good purpose and for the general welfare of the country.—U. S. Senator Hugh Scott in 87th Congress.

F. Robert Haase, M.D.

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Asbury Park

A Common Cause of Post Nasal Drip

Much of our study and research is concentrated on major problems. But the "minor" ones—like post nasal drip—need some thought and attention, too.

It is not unusual for a doctor to see two or three patients every day complaining of post nasal drip; yet it is uncommon for the most frequent source of this difficulty to receive attention. We were all taught that the respiratory passages are lined by a ciliated epithelium which has an intrinsic motion that allows it to act as a cleansing mechanism. At this point, however, further knowledge of this mechanism ceases to be taught; and its true physiologic value fails to come to light.

The physiologic respiratory mucosa is covered by cilia having an intrinsic beat of 12 per second.[1] The mucous coating, if in a physiologic state, will be dumped into the nasopharynx every 20 minutes. Along with it will go the particulate and microscopic matter collected from the inspired air. The process may be likened to a conveyor belt. It is an effective mechanical cleansing mechanism when functioning efficiently. Bacteria are not in contact with any single cell membrane long enough to penetrate it or even irritate it to a response. The material expelled in the nasopharynx is then conducted over the mucus-lubricated surface by gravity (and by the swallowing act) to the stomach where it is neutralized by gastric acids.

Conditions which inhibit or destroy the cilia are the common cold, the use of heavy metal salts, epinephrine and *drying*. This last condition is the greatest cause of post nasal drip and initiates the bulk of respiratory complaints.

The human body temperature is a constant at 98.6 degree Fahrenheit, therefore, any air inspired at a temperature of less than 98.6 degrees Fahrenheit is going to be heated to that temperature and expanded in volume as a result. That air is heated to body temperature on inspiration has been proved by temperature readings taken in the nasopharynx. Air from -40 degrees Fahrenheit up has been found to be heated to 97 or 98.6 degrees Fahrenheit by the time it reaches the nasopharynx. Truly a remarkable heating system! Expansion of the inspired volume of air must take place. Relative humidity of the inspired air must drop as the air is expanded unless something occurs to humidify the air as it is expanded. To illustrate: atmospheric air at 50 degrees Fahrenheit and 100 per cent humidity when heated to 98 degrees Fahrenheit will expand five times and the relative humidity will drop to 20 per cent.[2]

The relative humidity of inspired air in the trachea is 100 per cent regardless of atmos-

1. Proetz, A. W.: Applied Physiology of the Nose, Annuals Publishing Co., St. Louis, 1941.
2. Data Calculated from Smithsonian and other standard tables.

pheric humidity. Obviously, then, humidification has taken place during inspiration. The moisture must have been obtained from the only available source in the respiratory tract: the mucus coating the respiratory mucosa. *This is a drying process* as regards the mucus covering the respiratory membrane. In fact, the loss of moisture can be felt by simply expiring on one's own hand or even be seen in cold weather, when one can "see one's own breath," as the moisture in the expired air condenses!

WHAT then is the result of moisture loss from the respiratory tract? The protein fraction of the mucus becomes partly precipitated leaving an opaque, viscid secretion which is tenacious and clings to the underlying mucosa. Complete drying results in crusting. The cleansing time is thus prolonged due to the tenacious secretion bogging down the cilia. Also incorporated in the stagnated secretion are the bacteria, lint, dust and other particulate matter removed from the inspired air.

Now the bacteria are in contact with a single cell membrane long enough to create an irritative response or to secrete their enzymes, break down the cell membrane and enter. The body now reacts in the only way in which it can. More blood is brought to the area to bring white cells and antibodies to defend against the threatened invasion. This is congestion! In the latter circumstance the influx of organisms results not only in congestion but also in a build-up of the local neutralizing tissues, the lymphoid accumulations of the adenoid and tonsils.

Consider for a moment a child in whom the widest portion of the naris is only 3 millimeters. One millimeter of congestion will block two-thirds of the passage! Now interpose a one millimeter layer of viscid mucus and you have complete obstruction! Over a period of time the lymphoid accumulations are going to increase in size and add to the obstruction.

Thus, in a physiologic state, a certain amount of post nasal drainage is normal. This, however, is asymptomatic. The condition becomes symptomatic when the secretion becomes viscid and tenacious. The common complaint of "a lot of post nasal drip" is a paradox, for it is not the *volume* of secretion which has become symptomatic but rather a change in the *character* of that secretion. Viscid secretion clings and is not easily moved, may cause gagging, is stretched by the alternating air stream and is sensed by the patient's tactile mechanism, frequently causing dry cough.

Other conditions which may be initiated by the basic mechanisms described are sinus and eustachian tube obstruction resulting in sinusitis, hearing defect and infectious ear conditions. Sore throat and chronic bronchitis are also frequent additional by-products.

WHAT then is the treatment? Best results are going to be obtained by maintaining a physiologic respiratory mucosa. The treatment must then be preventive.

First and simplest is good hydration: drink plenty of water.

Perhaps the greatest difficulty is the sleeping period. During this time there is continuing loss of fluid on expiration. This loss is not replaced (as it is during the waking hours) and leads to a considerable drying out of the body. In a child this is particularly important since 10 to 12 hours of the day may be so consumed. In addition their fluid reserve is small as compared to that of the adult.

Treatment of this phase can be best approached by having a vaporizer in the room in which the person sleeps. This apparatus must be run during the entire sleeping period. Doors and windows must be kept closed and the temperature at 70 to 72 degrees Fahrenheit. This can be a nuisance in that moisture may collect on the windowpanes and sills or cold walls. Covers may be kicked off during sleep, although this is no problem if there is no draft. None of the inconveniences is of any consequence if the need is sufficient. Continuous controlled humidification may be obtained in the entire home by installation of an adequate system on a forced hot air furnace or similar systems manufactured for other

household heating plants. The output of such systems is controlled constantly by a "humidistat."

Individuals having to work in hot, dry areas and having difficulty with nasal drying may spray the nose every two hours or so as an aid. A used "Spraypak®" containing normal saline or a small atomizer may be carried in the pocket for this purpose.

CONCLUSION

HEAT and adequate humidity are both necessary to the physiologic mucous membrane. Neither one alone is sufficient. The greater portion of respiratory complaints seen in the practitioner's office today is initiated by or the result of nasopharyngeal and/or tracheobronchial drying.

601 Grand Avenue

A Trouble-Shooting Clinic

A walk-in, round-the-clock clinic for emotional problems is described by Bellak* as both a popular and unique arrangement. The "Trouble-Shooting Clinic" of the City Hospital at Elmhurst, New York City, created in October 1958, "has been successful in finding acceptance and in serving a useful community function." A total of 2,000 persons have been treated so far. The clinic is part of the hospital's community program for emotional problems. It includes psychiatric seminars for general practitioners, chaplains, guidance teachers, and lawyers. A school for parents and a program for children are now being developed.

"It has been our aim . . . to reach key community figures . . . with the specific purpose of creating, in our community, an awareness of psychiatric problems and a sounder psychodynamic understanding."

Dr. Bellak, instigator of the trouble-shooting clinic, termed it a place where "anyone may walk in and simply talk things over."

"It is geared to offer on-the-spot treatment for troubled feelings and the vexing, ordinary problems of everyday life. We want to teach our population to deal with minor disturbances."

The one-year seminar program for the general practitioner was created because the G.P. is often the first to have the opportunity of recognizing a psychiatric disturbance.

The course acquaints the general practitioner with basic psychiatric concepts and with methods of dealing with some of the psychiatric aspects of physical illness.

The seminar for clergymen enables the minister "to fulfill his religious role more effectively by clearly delineating religious problems from other problems, and by being able to serve his parishioners to some extent in the nonreligious roles thrust upon him."

The seminar for teachers was created "to make school personnel more perceptive in spotting early signs of trouble and more effective in utilizing the therapeutic resources of the community by imparting to them some understanding of pertinent psychiatric and psychodynamic concepts."

The program for lawyers "was originated because many matters brought to an attorney's office have emotional undertones."

A schedule for a "routine" annual psychiatric examination of children currently is being worked out "in the belief that early recognition of emotional turmoil can most frequently arrest further serious development."

Plans for the "school for parents" call for courses to convey basic information concerning the emotional development of children at different age levels and roundtable discussion.

"In our society, there is considerable pressure on parents to take the blame for many current juvenile difficulties."

There also is a "growing group of more sophisticated, psychologically oriented parents who wish for something beyond what the local school, pastor, or educator can provide."

"If general hospitals across the nation were to incorporate the idea of a trouble-shooting clinic, a major step might be made in preventive psychiatry. The psychiatric arm of any hospital assumes a sociologic function in our world of 'lonely crowds' . . .

"The Trouble-Shooting Clinic and the key figures of the community who have acquired some psychodynamic understanding may serve some of the functions of friend, neighbor, family doctor, or even of the closely knit family that has disappeared in the swift changes of our technologic society."

*Bellak, Leopold: December 31, 1960 issue of the Journal of the Americal Medical Association.

Barnett Elkin, M.D.

Paramus

Physical Medicine and Rehabilitation in the Treatment of Low Back Pain*

"Oh my aching back," has become a battle cry for civilized man. Perhaps the vertebral column was never meant to function in a vertical stance. Dr. Elkin here gives some tips on diagnosis, rehabilitation and prevention.

The diagnosis and treatment of low back pain involve the disciplines of internal medicine, neurology, orthopedics, radiology, industrial medicine, psychiatry and physical medicine and rehabilitation. The vast economic and social implications of this problem resulting in major losses to industry, business and government have led to specialized clinics set up by private insurance and governmental agencies.

More than anything else, low back pain is a result of imbalance between the duration and quantity of stress and strain put upon the supportive structures of the back and the ability of these structures to maintain this load without pathologically altering its physiologic state. A patient with faulty posture who maintains balance of his body structure with continued increased ligamentous and muscular work is subjecting ligaments and muscles to a relentlessly continuing load. This long duration small load may never cause decompensation but the individual will be more prone to "decompensate." Whether he does or not depends on type of occupation, the body weight, occurrence of trauma, state of tissues, anatomic relationships and the individual muscle strength and balance.

Russek[1] has estimated that 60 per cent of cases of back pain are caused by stress and strain, 30 per cent by fatigue, 5 per cent by instabilities and 5 per cent by other causes.

Much has been written on the mechanics of low back decompensation. I would like to limit the discussion to certain aspects of prevention, diagnosis and treatment of the low back syndrome. This syndrome may be defined as a painful condition of the lower back area (with or without radiation into other areas) caused by stress or strain, fatigue, trauma or degenerative changes in the bony, ligamentous, muscular or intervertebral disc of the lumbosacral area.

Ruptured, prolapsed or herniated disc remains a separate entity and depends upon the clinical findings of hypoactive reflexes, motor involvement, muscle atrophy or hypesthesia. Useful verifying tests are electromyography for motor root involvement, discography and myelography if operative procedure is contemplated.

Referred pain down the lower extremity can be produced by terminal nerve endings in the soft tissues of the back (including the disc) and is not in itself a positive sign of nerve root compression. Limitation of straight leg raising, radiation or localization of pain, restricted

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range of motion of the spine can all occur with varying pathology of the low back area and cannot be used as positive evidence of a herniated disc.

The following should be considered in the differential diagnosis of low back pain:

1. Herniated intervertebral disc
2. Rheumatoid arthritis
3. Osteoarthritis
4. Metabolic diseases, including osteoporosis, Paget's disease, osteitis fibrosa cystica and osteitis condensans ilii
5. Abnormalities of vertebrae and alignment, including spondylolisthesis, spondylosis, spina bifida, hemivertebrae, facet slipping and sacralization of lumbar vertebrae
6. Coccygodynia
7. Tensor fascia lata tightness
8. Trauma to vertebrae, including recent and healed fractures
9. Piriformis muscle syndrome
10. Sciatica (on infectious or neuritic basis)
11. Neoplastic diseases, benign or malignant. In the former category are such masses as hemangiomata, fibromata, and perineural cysts. Malignant tumors include lymphomata, multiple myelomata, and metastatic growths.
12. Infectious diseases such as tuberculosis and brucellosis as well as the usual pyogenic disorders
13. Occlusive arterial disease of iliac, femoral or aortic vessels
14. Dissecting aneurysm occurring while lifting heavy objects
15. Gynecologic and urologic disorders
16. Intra-abdominal visceral disease
17. Retroperitoneal masses of all types
18. Sacroiliac ligamatosis
19. Psychogenic disabilities

What factors increase the chance of development of a low back syndrome?

Poor posture means a less efficient mechanism of balance. As a result tissues work harder for longer hours "for the same wages," which is maintenance of balance. The back is therefore more susceptible to trauma, increased load or sudden, rapid motions. Some muscles and ligaments are strong and tight, others weak and stretched. For example, in the increased lordotic posture with tilting of the pelvis anteriorly, the back muscles are usually strong and tight. The abdominal and hamstring musculature are weak and hip flexors may be tight. The "tight" condition of the lower back leaves it susceptible to trauma on rapid forward flexion as in bending to retrieve an object from the floor. If lordosis exists without back muscle tightness, forward flexion will not cause pain but maintaining an erect position for long periods will.

As in the above example, disturbed mechanics related to a flattening of the lumbar curve, or a lumbar kyphosis can cause pain. Other defects such as unequal leg length, asymmetrical gluteii, pronated feet, tight heel cord, and hip flexion contracture may cause low back pain. Environmental conditions such as inadequate low back support by most automobile seats (leading to poor sitting posture) will cause fatigue after long hours of driving. Soft mattresses which fail to support proper vertebral alignment during sleep may play a part in the development of acute back pain.

Relaxation of the ligamentous system of the back, such as the supra-spinous and interspinous ligaments, resulting in instability of joints may cause pain from stretching of abundant sensory nerves in ligaments at their bony attachments.

Increased degenerative processes in the intervertebral disc plus increased load may cause damage leading to loss of elasticity. Such a disc permits anterior-posterior sliding motions of adjacent vertebrae with resultant pain.

Weak musculature, particularly in the overweight, may cause low back pain.

Lifting heavy objects improperly.

The degenerative and congenital conditions in the tabulation above.

The evaluation of a patient with a "low back syndrome" requires a systematic approach as follows:

I. History

(a) How and when did pain start?
(b) Type, localization and radiation of pain?
(c) Does intensity vary mornings, evenings or night?
(d) What bodily positions or movements cause the greatest pain?
(e) What bodily positions provide the greatest comfort?
(f) Have there been past episodes of low back tiredness or pain and how long did they last?
(g) Can the patient stand erect, walk, work, sleep?
(h) Social, emotional and psychologic history
(i) Is compensation or a law suit involved?

II. Physical Examination. This may be restricted during acute phase due to pain.

(a) Posture of individual standing and sitting (a plumb line is helpful), lordosis, flattening, kyphosis, scoliosis, abnormalities of leg length, position of feet, asymmetric musculature.

(b) Range of motion test of spine and lower extremities—Note movements which cause pain.

1. Hamstring length—straight leg raising and measure angle at hip which should be about 80 degrees.
2. Total length of back muscles and hamstrings—Touch floor with straight knees. Measure the distance from the tips of the middle fingers to the floor. Normal should touch floor.
3. Note mobility of lower spine by marking off ten inches and measuring again after flexion. Test lateral bending and hyperextension if tolerated.
4. Test internal and external rotation at the hip.
5. Test dorsiflexion of the foot with raised leg. Sharp pain may indicate sciatic involvement.
6. Test maximum hip flexion with flexed knee. Sharp pain indicates ligamentous involvement.
7. Maintain maximum flexion of one leg and attempt to fully extend other. Sharp pain indicates sacroiliac involvement.
8. Muscle Test. Compare power with other extremity. Quick screening test with patient sitting on examining table. Here is the way the muscles are provisionally tested:

1) Extensor hallucis—Resist extension of first toe.
2) Peroneal—Resist lateral motion of foot.
3) Posterior tibial—Resist medial motion of foot.
4) Anterior tibial—Resist dorsiflexion of foot.
5) Gastroc-soleus—Resist plantar flexion of foot.
6) Quadriceps—Resist extension of knee.
7) Hamstrings—Resist flexion of knee.
8) Illio-psoas—Resist flexion of the hip.
9) Lower abdominals—Patient supine, raises both legs to 30 degrees above table.
10) Upper abdominals—Lock hands behind neck and have patient sit up while giving resistance at ankles.
11) Repeat test No. 10 with knees flexed and feet placed close to buttocks. This eliminates hip flexor action.
12) Lower back muscles—Patient face down with hips resting on a pillow. Give support at upper back and hips and have the patient raise both legs to a horizontal position.
13) Upper back muscles—Patient face down with hips resting on a pillow. Give support at lower back and legs and ask patient with hands behind neck to raise his chest to a horizontal position.

Neurologic examination includes scrutiny for coordination, asynergy, atrophies (always measure the circumference of each calf and each leg), hypertrophies, power and reflex reactions, including presence or absence of pathologic reflexes. The sensory examination must not be neglected. Check (and compare sides) for touch, pain, pressure, two-point discrimination, temperature sense and sensitivity to the vibrations of a tuning fork.

Finally, the examiner runs his fingers over each sacroiliac joint to feel if a marked ridge is palpable.

TREATMENT

IN FORMULATING a treatment plan, the practitioner should classify the disability as very acute, acute or less acute. These are not, of course, sharply defined. While these phases merge into each other, the general pattern is:

1. Very acute—Patient has extreme pain, is bedridden and guards against slightest movement.

2. Acute—Patient has extreme pain but may tolerate sitting and limited movement.

3. Less acute—Patient has pain but can continue most of his daily activities.

1. *Very acute cases*—Complete bed rest on a firm mattress with bedboard. Use analgesics such as aspirin or propoxyphene.† Moist heat. If necessary, apply pelvic traction. As condition improves continue therapy as outlined below.

2. *Acute case*—Apply moist heat to the low back area in the form of Hydrocollator® packs or Moistair® back unit. Low intensity diathermy, ultra-sound or Hubbard tank may be tried. Begin with sedative massage advancing to deep kneading. Use aspirin freely. If pain persists try ethyl chloride spray, procaine or hydrocortisone injections in specific palpable painful areas. Obtain a good-fitting custom-made corset with semi-rigid stays to be worn whenever the patient is sitting or erect. Continue supportive treatment that has provided the greatest comfort. Begin mobilizing the patient in a warm pool with water depth to patient's chest. As condition improves continue therapy as outlined below.

3. *Less acute case*—Apply moist heat and

†Commercially available under the Lilly tradename of Darvon® compound.

massage daily. Use any of the treatments described above, if necessary.

At this stage we are ready to recommend an exercise program to stretch tight tissues, strengthen weak muscles and, hopefully, to correct faulty postural habits. The information acquired from the range of motion and muscle tests provides a guide for specific therapeutic exercises. The program should never cause pain. It is held well below the patient's tolerance.

During this period, the total rehabilitation facilities, including vocational counselor, psychiatrist, occupational therapist, orthopedist, psychologist and general physician combine their efforts to assess the patient's problems in preparation for job placement.

The doctor explains to the patient the nature of the illness and that he must learn to work, play and conserve a back that has been neglected for many years. He is instructed as follows:

1. Sleep on a firm mattress with bedboard.
2. When sitting do not slouch. Learn to bring the small of the back flush against a firm support.
3. When driving use a firm back support of adequate thickness so that the small of the back remains flush against it.
4. Never pick up a very heavy object.
5. Turn toward the object you are picking up.
6. Never bend at the waist. Bend at the hips and knees.
7. Lift with your legs and not your back.
8. Avoid sitting in chairs and couches that are extremely soft or low.

The vocational counselor analyzes his present position and efforts are made to *return him to work as quickly as possible*. This is an essential part of treatment of the low back syndrome. There is nothing worse than a patient with low back pain and too much time on his hands. Until job placement is accomplished use maximal occupational therapy.

Most individuals with low back problems are *not* malingerers. They are angry with anyone not fully sympathetic with their present plight. They feel they deserve Workmen's Compensation or other insurance and they have their back pain to prove it. The psychiatrist (or if one is not available, a psychologist) works with the patient to prevent a chronic psychogenic overlay which is a significant impediment to successful treatment. He permits the patient to vent his angers and fears.

If the patient cannot return to a position in which he has experience then he should be retrained for a position that is least traumatic for his condition. Employment and settlement of claims is essential to recovery.

The treatment of the herniated disc is of particular interest. In this lesion, low back pain persists in a significant proportion of cases after operative procedures. Conservative management should therefore be tried on a maintenance basis as long as the patient responds and can function in society. In completely herniated disc (with increasing motor, and/or sensory involvement with no response to conservative management) or in instances of very frequent recurrences interfering with daily living, the indications for operative intervention are clear. As surgical management yields increasingly lasting results, such stringent requirements for operative treatment will vanish. Today, conservative management is preferred for most cases of herniated disc.

PREVENTION

IN PREVENTING these lesions, the physician should take a dynamic role. Prevention falls into three phases—general education, physical training and medical screening. Under the first phase is the development of a program for imparting information to the general public on posture, body mechanics, and sound technics of lifting heavy objects. In industry, such an educational program should be consistent and sharply focussed.

Persons responsible for physical education should develop a program of posture analysis and corrective exercises; and should take the lead in teaching good habits of sitting, standing, driving and lifting.

Medical screening includes the routine use of x-rays in industry to recognize congenital, degenerative and other back instabilities; to be followed by advisory and rehabilitative programs. Employees with unstable backs should be given assignments appropriate to that limitation.

SUMMARY

THE diagnosis of a "low back syndrome" requires the exclusion of many clinical entities that cause low back pain. A method of systematic evaluation is given. The treatment is discussed in relation to various stages of the condition and the rehabilitation processes described. The possibilities of methods of prevention are indicated.

The Bergen Pines County Hospital

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Ulcers and Disability

More than 2.4 million Americans have ulcers, and nearly three times as many men have ulcers as do women, the Health Insurance Institute reported recently.

Some 1,771,000 men have some form of peptic ulcer compared to 669,000 women. Ulcers are four times as common among Americans now as they were in the 1930's.

A survey in 1935 showed that three out of every 1,000 persons had an ulcer. The latest survey, covering 1959, disclosed that 14 out of every 1,000 persons were so afflicted. This quadrupling of the ulcer rate is due, in part, to more accurate methods of diagnosis through wider use of x-ray equipment. Apart from this, it appears that the prevalence rate of ulcers has quadrupled. Over a 20-year span, the rate of hospital admissions for ulcers has grown from four admissions per 10,000 persons per year to seventeen. Thirty per cent of these admissions had their ulcers treated surgically.

Ulcers were most prevalent among men in the age group 35 to 44 where 42 of every 1,000 males have ulcers. Highest prevalence for females was in the age group 45 to 54, where the rate was 18 for every 1,000 women.

The frequency of ulcers among men declined after age 45. In every age group, prevalence rate for women was less than half that among men.

In responding to the survey, 85 per cent of the persons with ulcers said they suffered no limitation on normal activity. The 15 per cent with restrictions were divided into 12 per cent who were limited in outside activities or in amount or kind of major activity; and 3 per cent who were completely unable to carry on major activity. One-fourth of the persons with ulcers spent a day or more in bed because of the ulcer in the past year; and about two-thirds of these spent seven or more days in bed.

Ulcers caused their victims to lose 12 million days from work during an average year. Based on the usual work year of 245 days, on an average work day 49,000 persons are absent from their jobs because of ulcers.

Robert S. Garber, M.D.

Belle Mead

Seminars in Psychiatry for the General Practitioner*

General practitioners today realize the importance of the emotional component. The problem facing us is how to maintain graduate instruction in this for the clinician.

The Carrier Clinic conducted three seminars in psychiatry for the general practitioner during the past four years. This is a review of the experiences gained, as well as a collation of critiques collected from 221 participants, a cursory outline of the format followed, and constructive suggestions for those who might be planning similar programs.

In November 1956, at the Annual meeting of the AMA Council on Mental Health, emphasis was on the need for developing psychiatric seminars for the general practitioner. The idea was nothing new—half a century ago Dr. Adolf Meyers stood before a conference of the New York State Commission on Lunacy to promote "a practical interest among practitioners in mental disease." Today this "practical interest" is almost a necessity. The medical practitioner has become keenly aware that emotional illness is no stranger in his waiting room, and that knowledge of psychiatric principles is as basic a tool for the treatment of physical diseases as the thermometer or stethoscope.[1]

As a consequence, the author, as Chairman of the Mental Health Committee of The Medical Society of New Jersey, determined that this would be a worthwhile project on which to embark, and consequently sought a sponsor. Such organizations were readily available but actual financial sponsorship was undertaken by the Carrier Clinic,† and further subsidized through grants by the Smith, Kline and French Foundation. Accordingly, a planning committee comprising members of the Mental Health Committee, the New Jersey Chapter of the American Academy of General Practice, and the administration of the New Jersey Neuro-Psychiatric Institute met to determine the format. The publication, "Teaching Psychotherapeutic Medicine" (published by the Commonwealth Fund as a result of an experience obtained by the University of Minnesota Medical School) was a guideline. We determined that it would not be advisable to offer brief, incidental lectures alone, but rather to put it on a more intensive graduate status. "Both family physician and psychiatrist know that the complex skills required to manage emotions related to medical and surgical illness cannot be learned from a textbook, journal, or incidental lecture alone, nor are they born full-blown from the good intentions of a loving doctor. As a result, family physicians have come to demand serious postgraduate training."[2]

*Read before the Section on Nervous and Mental Diseases, American Medical Association, Annual Meeting, June 28, 1961.

†The Carrier Clinic is located at Belle Mead, N. J.

1. Mental Health Forum, 4:56 (Feb. 1, 1961).

2. Sheeley, W.: "Psychiatry for the Non-psychiatric Physician: A Bibliography." Washington 9, D. C., 1960. American Psychiatric Association.

FORMAT

To effect a proper academic setting it was determined that the first series of lectures should be on the campus of Princeton University, which was near to the Clinic. Eighteen lecturers, of professorial level, were selected; and for six consecutive Wednesday afternoons in the Spring of 1957 three didactic sessions were held. As a result of critiques collected (which will be referred to later), the participants felt that the University setting offered certain disadvantages, *e.g.*, noisy environment, inadequate parking facilities, and difficulty in gaining access to the classroom. In addition, our critics felt that three solid hours of lecture, with only a few moments in between for brief questions was cumbersome. Accordingly, the subsequent seminars were conducted with twelve lecturers, allowing them one hour apiece, with a half hour for a liberal period of questions and answers. This same format was followed in the Fall of 1958 and the Fall of 1960 at the Carrier Clinic's conference room.

ATTENDANCE

Although Category I credit had been obtained from the New Jersey Chapter, American Academy of General Practice, it was felt that we should canvass *all* the licensed physicians in New Jersey. The entire membership of the State Medical Society (6000 members) was invited through direct mail. For the three seminars, attendance was as follows:

First Seminar— 86 registrants—Average attendance 60
Second Seminar—138 registrants—Average attendance 111
Third Seminar—125 registrants—Average attendance 79

However, for the third seminar series the invitations were sent out as enclosures in a Psychiatric Quarterly published by the Clinic.[3] We now know that many invitations were lost because of the failure of some participants to read the quarterly. This was verified by a number of physicians who were actively interested in the first two seminars but who were not aware that the third series was going on until it was under way.

CONTENT

The author attended the annual convention of the New Jersey Chapter of the American Academy of General Practice in January, 1957. I polled the members to determine their specific interest in psychiatric subjects for the first series. Each of the two subsequent series has incorporated specific topics selected by the previous participants, with some minor change in titles.

Consequently, the list of titles offered below has been entirely selected by physicians who attended the series themselves with one notable exception.

FIRST SEMINAR

"The Patient-Physician Relationship"
Milton Rosenbaum, M.D., Chairman, Psychiatry, Albert Einstein College of Medicine.

"The Use and Abuse of Tranquilizing Drugs"
Ivan F. Bennett, M.D., Chief, Psychiatric Research, Veterans Administration, Washington, D. C.

"Mental Health of Advanced Maturity"
Maurice E. Linden, M.D., Director of Mental Health, City of Philadelphia.

"The Management of Overeating, Overdrinking, and Oversmoking"
Leo Bartemeier, M.D., Medical Director, Seton Institute, Chairman, AMA Section on Mental Health.

"The Evaluation of the Patient's Emotional State by the General Practitioner"
C. Knight Aldrich, M.D., Chairman of Psychiatry, University of Chicago.

"Treatment Principles for Psychosomatic Disorders"
O. Spurgeon English, M.D., Professor of Psychiatry, Temple University Medical School.

"The General Practitioner and the Discharged Psychiatric Patient"
Kenneth E. Appel, M.D., Chairman of Psychiatry, University of Pennsylvania.

3. Abstracts in Psychiatry for the General Practitioner: A quarterly publication of the Carrier Clinic, Belle Mead, N. J.

"The Evaluation of Therapeutic Agents"
Stewart Wolf, M.D., Professor of Medicine, University of Oklahoma.

"Treatment of Psychosomatic Disorders"
Jacob E. Finesinger, M.D., Professor of Psychiatry, University of Maryland.

"How to Handle Psychiatric Emergencies"
Robert A. Matthews, M.D., Professor of Psychiatry, Jefferson Medical College.

"The Emotional Problems of Children"
John A. Rose, M.D., Director, Philadelphia Child Guidance Clinic.

"How the General Practitioner Can Contribute Toward Healthy Emotional Development"
Daniel Blain, M.D., Commissioner of Mental Health, State of California.

"Management of the Emotional Reactions of the Involutional Period"
Baldwin L. Keyes, M.D., Professor of Psychiatry, Jefferson Medical College.

"Approach to the Patient with Multiple Complaints"
Martin Epstein, M.D., Department of Medicine, University of Pennsylvania.

"Quieting the Disturbed Patient"
T. George Bidder, M.D., Associate Professor of Pharmacology, Western Reserve Medical School.

"Management of the Anxious Patient"
John A. P. Millet, M.D., Department of Psychiatry, Columbia University.

"The Value of Emotional Support and Environmental Manipulation"
Raymond W. Waggoner, M.D., Director, Neuropsychiatric Institute, University of Michigan Hospital.

"Management of the Depressed Patient"
Manuel M. Pearson, M.D., Associate Professor of Psychiatry, University of Pennsylvania.

SECOND SEMINAR

"Chronic Dependency—Its Reflection in General Practice"
Elmer L. Caveny, M.D., Director, Department of Psychiatry, University of Alabama.

"Signs of Incipient Psychiatric Illness"
Jack R. Ewalt, M.D., Commissioner of Mental Health, State of Massachusetts.

"School and the Adolescent"
Dana L. Farnsworth, M.D., Director of Health Service, Harvard University.

"Cerebral Vascular Accidents"
Francis M. Forster, M.D., Dean, Georgetown University Medical School.

"Research in Schizophrenia"
Robert G. Heath, M.D., Chairman of Psychiatry and Neurology, Tulane University.

"Who, What, When, Why and Where of Health and Illness"
George C. Ham, M.D., Chairman of Psychiatry, University of North Carolina Memorial Hospital.

"Common Neurotic Reactions of Elderly Patients"
Ewald W. Busse, M.D., Chairman of Psychiatry, Duke University.

"Psychiatric Aspects of Murder"
Manfred Guttmacher, M.D., Chief Medical Officer, Supreme Bench of Baltimore.

"Office Management of the Neurotic"
William Malamud, M.D., Director of Psychiatry, Boston University.

"Evaluation of Interviewing Technics"
Henry W. Brosin, M.D., Chairman of Psychiatry, University of Pittsburgh.

"The Psychiatric Patient in a General Hospital"
Harvey J. Tompkins, M.D., Clinical Professor of Psychiatry, New York University.

"The Physician's Use of Himself as an Instrument in Treatment"
Hugh T. Carmichael, M.D., Professor of Psychiatry, University of Illinois.

THIRD SEMINAR

"Management of the Aged: Treatment *Vs.* Hospitalization"
Walter E. Barton, M.D., Associate Professor of Psychiatry, Boston University.

"Symptomatology of Conversion Phenomena"
M. Royden C. Astley, M.D., Chief, Psychoanalytic Service, University of Pittsburgh.

"Hypnosis and the Physician"
Harold Rosen, M.D., Assistant Professor of Psychiatry, Johns Hopkins University.

"School Phobias"
J. Franklin Robinson, M.D., Director, Children's Service Center, Wilkes-Barre, Pa.

"Whiplash Injuries and Their Psychiatric Implications"
John Donnelly, M.D., Assistant Professor of Psychiatry, Yale University.

"Psychosomatic Aspects of Obstetrics and Gynecology"
Edward C. Mann, M.D., Assistant in Gynecology and Obstetrics, Cornell University.

"Management of the Mentally Retarded"
Cecil Wittson, M.D., Chairman of Neurology and Psychiatry, University of Nebraska.

"Doctor-Patient Relationship"
Herbert S. Gaskill, M.D., Professor of Psychiatry, University of Colorado.

"Role of the Nervous System in Psychiatry"
Leo Madow, M.D., Chairman of Neurology, Woman's Hospital, Philadelphia, Pa.

"The Appropriate Time for Referral"
C. Knight Aldrich, M.D., Chairman of Psychiatry, University of Chicago.

"Anxiety—Case Demonstration"
Jules Masserman, M.D., Professor of Psychiatry, Northwestern University.

"Hormones and Behavior"
Howard P. Rome, M.D., Professor of Psychiatry, University of Minnesota.

CRITIQUES

FOLLOWING each of the seminar series, comments from the participants were solicited through three technics.

1. They were asked to complete a short questionnaire relative to the program format, *i.e.*, whether the content of the lectures was too specific or too general, whether they had any suggestions to make relative to future topics to be offered, and finally, any constructive alterations to the program.

2. Personal interviews were conducted by members of the Planning Committee. This resulted in more specific impressions, thereby aiding the Planning Committee in their future work.

3. *Telephone inquiries* were made by the Psychiatric Social Worker* of the Carrier Clinic staff along specific lines, such as:

a. Why they enrolled in the course?
b. What had been their expectations for the course?
c. Were these expectations fulfilled?
d. Was the knowledge gleaned from the seminar useful in their practice?

As a result of suggestions solicited from the participants themselves, the actual programming of the series has been realigned to meet changing needs. This has kept interest running high, hence the relatively low drop out rate. Finally, and more importantly, as a result of the collection of these experiences, we have been able to answer specific inquiries from individuals in the four areas of the country who have sought information about the planning of their programs.

SUGGESTIONS

One general comment seemed to characterize the statements collected from the participants; namely, that although not all the material was germane to the work they did, they nonetheless were convinced that they had gotten a new appreciation of the importance of the psychologic aspects of every field of medicine. One participant put his impressions this way—"The seminar enabled me to see myself in a different role as a physician, particularly how my own emotions entered into the management of a particular problem which I now recognize was 99 per cent functional, so that I was far better able successfully to treat the patient, consequently relieving my own guilt and providing a better result." Diverse other suggestions were forthcoming: for example, (1) Although a number of physicians particularly appreciated that the lectures were in Category I of the American Academy of General Practice sponsorship, many came to realize that, whether or not they were in such a classification, they would still desire to attend them as long as the topics consistently proved to be of such value. (2) Others appreciated information which would be of help when dealing with their patients in maintaining good mental health, *i.e.*, something which they could give their patients in relation to positive mental attitudes, rather than treating an advanced illness; for example, Mann:[4] "Habitual aborters are women, who for psychologic reasons doubt their abilities as prospective mothers and tend, during pregnancy to be beset by increasing anxiety expressed usually by way of uterine contractions. Psychiatric treatment not only helps the patients to overcome their fears and doubts but also to mature emotionally." (3) Others were interested in practical and usable ideas that would be applicable to industrial work; for example, Donnelly:[5] "When man is in trouble, he is greatly comforted and his disturbing emotions quieted when he is given the opportunity to discuss his feelings whether these be his hostility to the 'aggressor,' the offending driver, or his anxiety about the meaning and import of his symptoms. This opportunity to ventilate his feelings contributes to his more speedy recovery. Reassurance has long been part of the physician's armamentarium and, in cases of whiplash injury, it should not be neglected and its importance in preventive medicine must be realized." (4) Others found that lecturers on such topics as hypnotism, mental retardation, and aging, actually punctured a few 'pet notions' that they had about such topics; and that they were successful in obtaining suggestions as a

*Mrs. Belle Parmet, Psychiatric Social Worker.

4. Mann, Edward C.: Seminar. Third Series, 3:3 (November 1960).

5. Donnelly, J.: Seminar. Third Series, 3:3 (November 1960).

result which were of great help, and of practical value; for example, Linden:[6] ". . . Stimulation or tranquilization alone is of little value unless it is accompanied by a broad program of activities and therapies that simultaneously furnish the supplies for physiologic and psychologic needs. Giving a pill cannot substitute for the human relationship that these socially deprived oldsters require. The capacity of older patients to respond to real treatment programs is remarkable and much greater than is popularly believed, even among physicians. Eighty per cent of the elderly patients, no matter where you get them or what their complaint, will respond to some form of therapy providing it has a human element. It isn't as we say, the giving of the *pill* that makes the difference, but the *giving* of the pill that helps in the response." (5) Finally, a significant group reported on the benefits obtained from learning a discreet manner in which to refer a patient to a psychiatrist or a psychiatric facility, expressing their own conscious awkwardness in accomplishing this fact without creating the impression in the patient's mind that they were considered by the physician to be "crazy." Thus, Carmichael:[7] "Frequently, however, it is the doctor's own personality which determines his choice of the type of management for an illness and the tendency is for him to revert to his habitual bedside manner regardless of whether it is appropriate to the situation or the patient. This bedside manner is a defensive system behind which the doctor hides whenever he is troubled or concerned over a patient whom he does not understand, or whenever he feels insecure, apprehensive or prejudiced in any way."[8] Over and above, these specific suggestions as enumerated above, the Planning Committee has found that it is important:

1. To provide lectures that will rate a Category I, sponsorship of the American Academy of General Practice.
2. To utilize those individuals most frequently involved in teaching, if possible, those from an academic setting and/or professorial rank.
3. To stress topics suggested by the participants (or those which are of obvious interest).
4. To allow ample time for questions and answers, even—if necessary—to provide for an open meeting so that doctors can remain to satisfy their wish for knowledge on a certain subject.

The Planning Committee has also found that it is not always feasible nor necessarily desirable to use "live clinical presentations," but frequent use of *current case material* is profitable and forever stimulating. *Also,* we have agreed that the goal is *not* to train general practitioners to be skilled psychotherapists but rather to develop understanding of emotionally-laden situations which can be masked—by pain, withdrawal, or euphoria—*and* to develop the necessary finesse in referrals.

PITFALLS

No program of this nature could ever be successful, unless the achievement level of the group is estimated accurately and the lectures planned accordingly. From our experience in conducting three such seminars we have learned the following:

1. Impress upon the lecturers the necessity of discussing any analytical material (or psychodynamics) in plain and understandable terms to avoid doubts or confusion.
2. Encourage the lecturers to avoid a "condescending" attitude which would imply that they are giving the general practitioner a "pat on the back for the job he is doing in the community."
3. Avoid material which provides no specific help. Concentrate on *definite* ideas that the general practitioner can actually apply in his practice. Omit generalities.
4. Make certain that the lectures avoid endless recapitulation of historical facts, statistical charts or figures and recitation of a long series of successful accomplishments.[9]
5. Avoid the attitude conveyed by some lecturers who feel that they are still teaching medical students and consequently talk down to their audiences.

6. Linden, M. E.: Seminar. First Series, 1:5 (April 1957).

7. Carmichael, H. T.: Seminar. Second Series, 2:1 (February 1959).

8. Garber, R. S.: "Building an Effective Physician-Psychiatrist Team." Paper read September 15, 1959, before the Annual Meeting of the Kentucky State Medical Association.

9. Garber, R. S.: Kentucky State Medical Journal, 35:45 (February 1960).

CONCLUSIONS

THE tranquilizing medicines and the tremendous progress made in various forms of therapy have placed a further demand on the general practitioner's specific skills. There is an inadequate number of trained psychiatrists to cope with the ever-increasing number of patients turned back into the community for follow-up care once discharged from public or private hospitals. In a recent address Felix,[10] estimated that about 60 per cent of patients in the physician's office have conditions which are, in significant part, emotional in nature; and that, of the remaining 40 per cent whose illness is largely organic, there are emotional problems which must be taken into consideration in the treatment process. Thus, the psychiatrically attuned general practitioner will be of inestimably more value to his patient; and he will, for himself, gain more professional satisfaction. Consequently, it would behoove every state and county medical society, every chapter of the American Academy of General Practice, every mental health committee of a component medical society and every similar professional group, to encourage psychiatric seminars of high calibre for interested general practitioners. The mechanics are not difficult to organize; participants are eager to enroll; and lecturers are readily available (virtually all who have been invited are pleased to provide assistance). Results are so rewarding as to be stimulating to all who participate in the planning and thus encourage them to continue the seminars on a regular schedule.

SUMMARY

THREE separate psychiatric seminars for the general practitioner were conducted at 18-month intervals, under the sponsorship of the Carrier Clinic.† The responses have been heartening and so encouraging as to require that they be programmed on an annual basis. The assistance obtained by the general practitioner participants (as well as those providing the program) has reaped manifold dividends. This is reflected by observations of those in the immediate area who report the tremendous advantage of seeing evidences of the emotional health of their community improve.

10. Felix, R. H.: Paper read April 14, 1961, before the Southern Regional Educational Board.

The Carrier Clinic

Speed Still Kills

Compilations by the Travelers Insurance Companies show that persons killed last year in highway accidents blamed on excessive speed totaled 10,970 as compared with 12,980 in 1959. This report is included in the safety booklet published annually by The Travelers since 1931 and distributed to more than 3 million persons.

"Citizens' organizations throughout the country should take heart in these figures," said J. Doyle DeWitt, president of The Travelers. "This decrease in deaths-due-to-speed is even more significant when you realize that it came in a year when highway accidents actually killed 400 more people than a year ago. Speed has long been blamed as 'the number one killer on our highways'."

"Even with the improved speed record last year," Mr. DeWitt said, "speed was listed as the primary cause of accidents which accounted for 36 per cent of the total deaths. As for injuries, the record was not as good. They increased nearly 100,000 with more than 1,000,000 blamed on speed during the year."

Abdolali Khajavi, M.D.

Newark

Hydrochlorothiazide in Congestive Heart Failure and in Toxemia of Pregnancy†

Hydrochlorothiazide is found to be a swift and effective diuretic, which can be conspicuously potentiated by administration of parenteral mercurials.

Diuretic therapy has been significantly advanced with the development of orally active sulfonamide compounds. Acetazolamide (2-acetylamino-1, 3, 4-thiadiazole-5-sulfonamide), the first of these, produced diuresis by the inhibition of carbonic anhydrase.[1] Chlorothiazide (6-chloro-7-sulfamyl-1, 2, 4-benzothiadiazine-1, 1-dioxide) and then hydrochlorothiazide* (6-chloro-7-sulfamyl-3, 4-dihydro-1, 2, 4-benzothiadiazine-1, 1-dioxide) followed. Hydrochlorothiazide* is ten times as potent as chlorothiazide. It is less toxic and is presently the oral diuretic of choice.[2]

These agents act on the proximal renal tubule and produce a diuretic effect similar to that seen with the mercurials. Sodium and chloride are eliminated in practically equal proportions,[3] while much less potassium and only a little bicarbonate are lost.[4] A mild shift toward hypochloremic, hypokalemic alkalosis has been observed. Diuretic potency approximates that of the parenteral mercurials. Tolerance is not a problem. Even on long-continued use, homeostasis is not seriously disturbed, and toxic effects are limited.

Hydrochlorothiazide* exhibits a hypotensive action which makes it useful in the treatment of hypertension. Evidently it blocks some of the action of norepinephrine,[4] but the precise mode of action, both as a diuretic and as a hypotensive agent[5] has not, as yet, been fully explained.[6] Glomerular filtration rate or renal plasma flow[6] are not altered by this compound under normal conditions.[7] Normal blood pressure remains the same,[6] and development of adrenal regeneration hypertension is inhibited.[8] Conspicuous diuresis occurs within approximately two hours after hydrochlorothiazide* ingestion, and depending upon the dosage, may last as long as 24 hours.[9]

Hydrochlorothiazide* produces abundant

†From Martland Medical Center in Newark.

*The hydrochlorothiazide used in this project was the Ciba brand tradenamed Esidrix®. It was supplied through the courtesy of R. D. Graupner, M.D., of Ciba Pharmaceuticals in Summit, N. J.

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Unique Course for General Practitioners

A varied program aimed at the general practitioner, featuring advances which he can apply to office practice will provide the theme for the "Temple University Medical Alumni Homecoming," April 27 and 28, 1962. It includes material on alcoholism, common orthopedic problems, newer drugs in heart disease and hypertension, the use of oral antidiabetic drugs, antibiotic therapy and infections, and the management of headache.

Formal presentations will be interspersed by workshops aimed at office practice or management of common medical problems. Registrants will be able to select any three workshops. The committee has applied for American Academy of General Practice credit. For more details and registration forms, write to Graduate School, Temple University Medical Center, Ontario Street at Broad Street, Philadelphia 40, Penna.

New President for Industrial Physicians

On February 1, Dr. Angelo D. Calabrese, plant physician for Hoffmann-La Roche, Inc., was elected president of the New Jersey Industrial Medical Association. Dr. Calabrese attended Seton Hall University and received his M.D. in 1947 from Hahnemann Medical College. He interned at Newark City Hospital, and served American Cyanamid Company in Bound Brook, as an industrial physician. In 1957, he became plant physician at Hoffmann-La Roche.

Dr. Calabrese is a member of the American Academy of Occupational Medicine and the Essex County Medical Society.

Elected to serve with Dr. Calabrese were Dr. Mathilda R. Vaschak of Squibb, as vice-president; Dr. Edmund M. Hartmann of American Cyanamid Company, as treasurer; and Dr. Edwin Merrill of Manville, as secretary. All these officers are members of The Medical Society of New Jersey. The New Jersey Industrial Medical Association numbers among its members 135 physicians from all branches of industry in our state.

Chest Disease Course Available

Here's a chance to bring your family to the invigorating Saranac area this June and to learn something about chest diseases.

The Trudeau School of Pulmonary Diseases will hold its 47th session in Saranac Lake, June 4 to 22, 1962.

The faculty includes specialists from all over the East. Half the time is devoted to tuberculosis and the other half to silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias, and intrathoracic tumors.

The course is a thorough review for specialization in pulmonary diseases or for work in public health involving tuberculosis. Since enrollment is limited, application should be made early. Write directly to the Trudeau School, Box 670, Saranac Lake, New York. Tuition is $100 for the three-week session.

Jersey Doctor Heads Gastroenterologists

Dr. Theodore S. Heineken of Glen Ridge, N. J., has been elected president of the American College of Gastroenterology.

Dr. Louis Ochs, Jr., of New Orleans, La., who was inaugurated as president in October of 1961, submitted his resignation to the Trustees, citing poor health as the reason.

Dr. Heineken, the new president, has been governor of the College for New Jersey; has been secretary, and has held office as vice-president.

Current Venereal Disease Literature

An up-to-date collection of abstracts on venereal disease is now available. Under the designation *Current Literature on Venereal Disease*, it is issued quarterly by the U. S. Public Health Service and is yours without charge. Write to Chief, Venereal Disease Branch, U.S.P.H.S. Communicable Disease Center, Atlanta 22, Georgia, and ask to be placed on their mailing list.

County Society Reports • • •

Camden

The January general meeting of the *Camden County Medical Society* convened at Cherry Hill Inn at 9:30 p.m., January 4, with Dr. William T. Read, president, in the chair.

Drs. Robert J. Maro and Francis J. Warner were sworn in as active members by transfer; and Drs. Gerald D. Grant, Warren Grover, Biruta Liepa, Sol Lubin, George E. Sebastian, Joseph A. Riggs, and Benjamin H. Williams, as associate members. Upon signing the register, they were introduced to the membership and presented with Indoctrination Kits. This was the first time the Indoctrination Kits were given.

Dr. Robert L. Breckenridge, chairman of the Program Committee, introduced Captain F. K. Smith, director of the Aviation Medical Acceleration Laboratory, Johnsville, Penna., who presented a program on "Aerospace Medicine." Captain Smith showed slides illustrating space flight and a film on the "Project Mercury" program.

Dr. Read called attention to the Indoctrination Kits and the vast amount of work that had been done in their preparation, and commended Dr. Herron and his committee on their achievement.

The secretary presented for second reading a proposed revision to bring our constitution into conformity with that of The Medical Society of New Jersey with regard to payment of dues. This would add the sentence: "If a member has not paid his dues and assessment by June first, his name shall be dropped from the membership rolls." This proposed revision passed unanimously.

It was reported that our Executive Committee had approved the Major Medical Expense Insurance program sponsored by the State Society. Dr. Grimes reported that on December 13, in conjunction with the Future Physicians' Club program, 60 high school students visited Jefferson Medical College, where they observed the basic sciences aspect of medical education. Their next visit is to be to the University of Pennsylvania, where they will get a preview of the clinical phase of medical training.

Dr. Caputi discussed a letter from the State Society asking each county society to name a panel to examine patients referred from the Division of Motor Vehicles. There was some uncertainty as to whether these panel members were to examine or review and some questions as to what liability would be incurred by a member serving on such a panel. A letter will be sent to the State Society asking for clarification.

Dr. Ecole J. Liberi was elected to fill Dr. Browning's unexpired term on the Executive Committee.

Dr. McAfoos recommended that the Society endorse the Blue Cross proposal that physicians submit a form stating whether a patient will remain more than 14 days in the hospital and to give an estimate of the number of additional days which will be required. This passed unanimously.

Dr. Read described a meeting held in Trenton to inform county society and Auxiliary officers about the King-Anderson Bill. Dr. Grimes, who also attended the meeting, added that the AMA opposes this bill and that the officials at the meeting felt a letter-writing campaign directed to our legislators voicing our personal opposition should be instituted. He further stated that the Auxiliary would cooperate in this project.

Considerable discussion took place as to the advisability of inviting the press to attend our meetings. A motion to invite the press to attend our meetings at this time was defeated by a hand vote.

FREDERICK W. DURHAM, M.D.

Reporter

Essex

The regular meeting of the *Essex County Medical Society,* held on January 11 in the Hotel Suburban, East Orange, was featured by a discussion of the financial problems of physicians. The speakers were William Allen Steadman and Paul O. Koether, well-known securities analyst, who reviewed the dilemma of the physician who has to decide whether to invest for income only or to speculate. There was also a discussion of mutual funds.

This unusual meeting was enlivened by much vigorous discussion from the floor.

HARVEY P. EINHORN, M.D.

Reporter

Hudson

With Dr. Nathan J. Plavin presiding, the regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center, on November 7, 1961. Dr. Ralph M. L. Buchanan, President of the State Society, and Richard I. Nevin, Executive Officer of the State Society, spoke on "Activities at the State Medical Society and Their Implications to You." Many members participated in a discussion from the floor.

Elected to regular active membership were: Drs. Jerome Cebula of Fort Lee, Joseph Fleisher of Bayonne, and William G. Wilkerson of Jersey City. Elected to associate membership were: Drs. Helen Davis, Martin J. Frank, Gustave A. Laurenzi, and Charles Zimmerman of Jersey City; Silvio DeAngeles of Secaucus; Mario Jascalevich of West

New York; and John Pellegrini of North Bergen. Elected from associate to regular active membership were: Drs. William A. Miles, Herbert M. Sinakin, and Frantisek Trunecka of Jersey City; Victor M. Kimel of North Bergen; N. Marchese of Union City; Gaspare F. Saitta and Endel Kask of West New York; and Gerta Schwarz of Weehawken.

With Dr. Nathan J. Plavin presiding, the regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center, on December 5, 1961.

Dr. Goeffrey Osler, Assistant Neurologist at Columbia Presbyterian Medical Center, spoke on "Problems with the Psychoneurotic Patient in Medical Practice." Many members participated in a discussion from the floor.

The recommendation that the Hudson County Medical Society offices be relocated in the Medical Arts Building in Jersey City was unanimously approved by the membership.

Dr. Fred Arkus of Jersey City was elected to associate membership at this meeting, and Dr. Anthony P. Lucci of Jersey City was elected to regular active membership.

Following the business meeting a collation was served.

CHARLES L. CUNIFF, M.D.

Reporter

Middlesex

The meeting of the *Middlesex County Medical Society* at Roosevelt Hospital, Metuchen, on January 17 was called to order at 9:15 p.m. by Dr. Thomas F. McLaughlin, the president.

The minutes of the December meeting were read. An error was noted in citing a resolution by the Hudson County Medical Society in which the president of the American College of Surgeons was criticized. The resolution actually referred only to the Secretary-General, Dr. Robert S. Meyers. This error was corrected. After correction was made, the December minutes were approved.

The Program Chairman, Dr. R. G. Matflerd, introduced the guest speaker, Dr. Gustave Lorenzi, Professor of Medicine, Seton Hall College, whose topic was "Chronic Respiratory Diseases and Bronchitis."

The chairman of the Public Relations Committee, Dr. D. T. Akey, gave a brief report of the meeting in Trenton January 4, where "Operation Contact" was discussed there. The various officials and auxiliary officials were briefed relative to the Social Security benefits for the "65 age group," which the Administration is seeking to have passed by the Congress. The members were advised to make every effort to prevent the passage of the King-Anderson Bill. It is the feeling of the State Medical Society officials and of the AMA that all members should make a concentrated effort using such means as for example, "Operation Contact" —which suggests that each physician contact ten other people and tell them of the seriousness involved, for example: the first steps toward a Welfare State; an additional unnecessary tax; and if all individuals write their representatives and Senators expressing reasons for opposing such a bill; then these ten individuals would in turn be asked to contact ten other persons enlightening them and advise them to do likewise.

Dr. McLaughlin said that the proposed bill is definitely unnecessary and that they should get more active and make every effort to help defeat the passage of the King-Anderson Bill. The physician must do all, within legitimate means to prevent further inroads on the regulation of medical practice by the Government. If this bill passes, its success will, in a large part, be due to the passive and disinterested attitude of the medical profession.

It was agreed to have the May meeting at the Forsgate Farms with golf, dinner and the showing of a film on Librium® on May 9.

Motions upholding the stand of the New Jersey Society of Pathologists against Senate Bill S.150 (of 1961), was endorsed by the membership.

The membership also agreed that members be asked to respond by card indicating whether they would attend the County Society meeting on April 18. This is to be a "husband and wife affair" and single physicians and their escorts are invited.

THOMAS F. McLAUGHLIN, M.D.

Reporter

Salem

The Philadelphia Air Defense Site at Pedricktown, New Jersey, was the meeting place for the *Salem County Medical Society* on January 19. The meeting was called to order by the president, William Sprout, M.D., at 4:45 p.m. Present were 28 active and one associate members. After a brief business meeting, the president discussed the proposed social-security bill for medical care of the aged. All present were urged to write to their Congressmen expressing their views. Dr. Garret Hume announced that members would soon be asked about their availability for giving physical examinations to the Boy Scouts at Camp Roosevelt, New Jersey.

Following a brief welcome address by the Deputy Post Commander, Major John S. Yarborough, the meeting was turned over to our host, Dr. Edwin Kellerman, Captain, M.C. His topic was: "Medical Aspects of Nuclear Radiation and Atomic Warfare."

After the discussion, a guided tour of the Nike Missile Master Building was held. The local defense for the Philadelphia Air Command was outlined. Afterwards, everyone retired to the Officers' Club for a delicious dinner of roast beef and fish.

JOHN T. DOOLEY, M.D.

Reporter

Book Reviews

The Life of Pasteur. Rene Vallery-Radot. Translated from the French by Mrs. R. L. Devonshire. Introduction by William Osler, M.D. New York, 1960, Dover Publications, Inc. Pp. 484. ($2.00)

The appearance of this standard biography of Louis Pasteur (1822-1895), in an inexpensive paperback is a welcome event. First published in two volumes in 1901, *La Vie de Pasteur* was reprinted five years later in the text from which the present translation was made.

Using letters and other personal documents, Vallery-Radot vividly reconstructs Pasteur's life and contributions to humanity. Pasteur has enriched the lives of all of us. Chemist and founder of modern microbiology, Pasteur combined inventive genius and personal idealism in unique fashion.

Devoting his energies early in his career to the microbial basis of fermentation, he introduced the process of partial heat sterilization (pas'eurization) for wine, beer, and milk. He studied anthrax and rabies, and developed the principle that pathogenic properties of micro-organisms can be attenuated by repeated animal passage. From this, came the 'Pasteur Treatment' for rabies. In promoting the application of his discoveries, Pasteur's genius for health education was almost as great as his scientific skill.

Sir William Osler writes in the introduction: "The Story of Pasteur's life should be read by every student. It is one of the glories of human literature, and, as a record of achievement and nobility of character, is almost without an equal . . . Before him, Egyptian darkness; with his advent a light that brightens more and more as the years give us ever fuller knowledge."

Fred B. Rogers, M.D.

The Hand. A Manual and Atlas for the General Surgeon. Henry C. Marble, M.D. Boston, 1960, W. B. Saunders Company. Pp. 200. ($7.00)

Allen B. Kanavel was the first American in the twentieth century to break the barrier of traditional "empiric" hand medicine. Sterling Bunnel wrote the "Bible" on the hand in modern times. This was expected to be a monument of surgical reference for years to come. In the past twenty years, a number of authors added to the "breakthrough" in hand surgery. Henry C. Marble's *The Hand* is one of the most recent additions in this special field of medicine.

This is not a book with detailed, voluminous references. Neither is it a lithograph of historical surgical developments. It has a special goal: to be a guide, a primer, a "quick reference" for the general surgeon, the general practitioner and any medically authorized personnel who may need help; even the "medical corpsman in a remote post or on a ship."

The author has nearly achieved his goal. A general surgeon himself, with a special interest in hand surgery, he is up to date, energetic, and practical within the scope of modern hand surgery. He is concise, but still touches every aspect of hand surgery—from fractures and staphylococcus infections to beryllium poisoning and contact dermatitis.

Dr. Marble stresses the prevention of hand injuries and skillfully points out the perils of hand surgery as well as its value and consequences. Fifty-eight plates by Mildred Codding deserve a special praise. They are skillful, well planned, informative, and considerably add to the value of this text.

The only weakness of this book is its onesidedness. It lacks references and fails to present other accepted methods of treatment. The author writes: "I have not reviewed several different methods, but have tried to discuss those that, after much trial and error, have worked best for me." The text is based on the methods developed or used by Dr. Marble and his associates at Massachusetts General Hospital. References to the recently enriched hand literature are very scarce. No matter how harsh a criticism can be made on all the variable aspects of *The Hand* by Dr. Marble, I am certain that I want it among the books on a handy shelf in my library.

Peter D. Argiroff, M.D.

Management of Hypertensive Diseases. By Joseph C. Edwards, M.D. with a foreword by Paul Dudley White, M.D. St. Louis, 1960, Mosby. Pp. 439. ($15.00)

For anyone to have the courage to write a textbook on the hypertensive diseases is of itself notable. To cover the field as completely as Dr. Edwards has done shows unusual ability to winnow the few grains of fact from the enormous chaff of traditional misinformation about this common disease group. Any physician who takes a patient's blood pressure would do well to read this book.

The first five chapters attempt to define arterial hypertension, by describing the physical changes associated with it, the laboratory findings in various forms of hypertensive disease, and finally the

natural history of essential hypertension. Although no true definition is found, there is a great deal of important knowledge in these chapters, gleaned from the very extensive literature and the vast experience Dr. Edwards has had with this group of disease states.

Five chapters are devoted to the treatment. Of greatest interest to the practicing physician is the chapter devoted to drug therapy, and the pharmacology of this group of chemical agents. This discussion outlines in detailed form the action, clinical use, and side effects of each of the compounds available.

The final chapter concerns the etiology of hypertension, especially essential hypertension. Although extensive reference to the literature has been made, etiology remains as aloof to Dr. Edwards as it has to all of his distinguished predecessors. It is far easier to say what essential hypertension is not than what it really is and what its causes are in the vast group of patients suffering from disease associated with high blood pressure.

CHESTER B. ALLEN, JR., M.D.

What Teenagers Want to Know. By Florence Levinsohn, M.A. and G. L. Kelly, M.D. Chicago, 1961, Budlong Press.* Paper covers. Pp. 89. Distributed through physicians only. ($1.50)

There are lots of things you can't learn from books: but these authors are sure trying. In this small volume, Mrs. Levinsohn and Dr. Kelly talk about sex problems, dating etiquette, self-understanding, the physiology of adolescent changes and the management of problem parents. Some of the material, especially in the anatomy and physiology sections, is a bit too technical and reads like the science books they wish on us in school. Generally, however, the authors manage to be serious without sounding solemn. And they see things through the teenager's eyes, and talk our language, too. They go straight to the point and most of the material is useful. This is a good book for any teen. And it makes excellent reading for a bright pre-teen, too. Come to think of it, it wouldn't hurt our parents to read it either.

TEENAGER ANONYMOUS

The Cardiac Arrhythmias; A Guide for the General Practitioner. Brendan Phibbs, M.D. St. Louis, 1961, Mosby. Pp. 128. Illus. ($7.50)

This amazingly compact book was written to teach practitioners the procedures required for the diagnosis and treatment of cardiac arrhythmias. It has accomplished its purpose extremely well. It is not a jejune work, nor a sophisticated one. It is a simple, clear and concise presentation of the subject.

The initial chapter reviews the basic anatomy and physiology of the heart. Sketches illustrate the sequence of events in normal and abnormal heart mechanisms. The normal electrocardiogram is described. Each segment of a graph is drawn to show the path of the impulse from the S. A. node spreading throughout the heart. The arrhythmias are described in detail. Sketches describe the origin and mechanism with numerous electrocardiogram tracings to illustrate each abnormality. Dr. Phibbs gives up-to-date material for each arrhythmia with proper administrative procedure and dose of each drug. He stresses precautions needed. A chapter is devoted to fatal arrhythmias and another to operating room emergencies. The use of the pacemaker, the open and closed chest method of resuscitation, and the use of drugs are described in detail and so presented that the procedures can readily be remembered. There is an instructive chapter on the author's clinical experience differentiating the arrhythmias. The last chapter offers exercises in electrocardiogram reading with the correct answers for those who wish a rapid review.

Arrhythmias cover 50 per cent of the cardiac maladies. This book gives a simple, understandable and working knowledge of this important subject. It is one to be read and re-read by every practicing physician.

NICHOLAS W. SIVOLELLA, M.D.

Abdominal Operations. By Rodney Maingot, M.D. London. New York, 1961, Appleton-Century-Crofts, Inc. Ed. 4. Pp. 1402 with 1800 illustrations. ($29.50)

This is a thorough revision of previous editions of this book. Edited by Dr. Maingot, it includes contributions by 36 other doctors both British and American. This excellent text contains much information beyond surgical technics. The historical notes set a valid background for the following text. The book is written in a pleasantly readable manner, especially those chapters prepared by Dr. Maingot himself. The illustrations are adequate and clear cut. The instructions are specific so that an attempt to reduplicate the technics as presented by Dr. Maingot should be relatively simple. In many areas Dr. Maingot injects his own direct and personal opinions on various procedures and states with authority the basis of his opinions.

While the reviewer had the book at hand, several specific and interesting problems came into his practice and reference to this text showed a very pointed commentary on each of the subjects encountered. The author's personal experience with a wide variety and frequently rare surgical problems is well documented in this book.

It is, of course, impossible in such a controversial subject as surgery to review a book of this magnitude and not find some points of dissent such

*5428 N. Virginia Ave., Chicago 25.

as the recommendation of a buttonhole incision or appendectomy during gastrectomy to relieve a focus of infection.

References to the literature are indicated in the text and it is possible to find more extensive detailed articles on various problems by starting with this book primarily. The indexing as to authors is very complete but I find the subject indexing not as extensive as I would have liked to have had it. There are several subjects which I did not find which need to be at least mentioned in this type of book, such as hypothermia for anesthesia, and localized hypothermia as Dr. Wangensteen practices for gastric bleeding. No extensive reference is made to the chemotherapy of malignant disease. British spelling, phrases, and phraseology, plus the use of English trade names for drugs, appear through the text.

SAMUEL J. LLOYD, M.D.

The Human Frame. By Giovanna Lawford. New York, 1961. Doubleday (Anchor Books). Pp. 109. Paper. ($0.95)

Anatomy is a dull and, in some respects, ugly subject. But when an artist like Giovanna Lawford looks at the human frame, it is visualized as a creation of fine symmetry. Here she takes the bones and invests them with beauty and grace. The skeleton, as she says "is the castle of our body; our home of a lifetime." There are bones that glide on others. There are hinges and there are cups in which glistening balls fit and turn in all directions. Each bone or group of bones is illustrated with a simple but effective line drawing that reminds one of the artistry of Renaissance illustrators. The total effect is curious: it is as if one somehow converted the traditionally dry-as-dust skeleton into an exciting poem. Hard to believe—but Mrs. Lawford does it.

ULYSSES M. FRANK, M.D.

Preventive Medicine in World War II. Volume V, Communicable Diseases. Prepared under dition of The Surgeon General, United States Army. Edited by Colonel John Boyd Coates, Jr., M.C. Washington, D. C. 1960, U. S. Government Printing Office. Pp. 530. ($5.75)

The work of many notable men both in civilian and military life, this book captures the imagination of anyone interested in preventive medicine. The book primarily covers the war years (1941 to 1945) and is supplemented by the additional work done since, bringing it up to date.

The medical text is subordinated to the preventive and historical side and the measures instituted to control each disease in the theatre in which the individual physicians were working. This makes the volume world-wide in scope. It shows the active part taken by the military in treating a civilian population to aid in controlling the spread of disease among the military personnel. This is particularly apparent in the long article devoted to venereal diseases. This book brings out what we learned in World War I and its influence on thinking in World War II. The lessons learned in this last war are to be the guides for the future in our military setup and will be augmented as our knowledge and experience are increased by further study.

The book is readable and most interesting. It will help the military and Public Health Services more than those in civilian practice who limit their work to one area of the country. For physicians in the reserve corps subject to military recall, it will be a tremendous help in preparing for an active career with army personnel. For these, it will bear careful reading and study. For the civilian it is historically interesting and informative.

JOSEPH W. GARDAM, M.D.

Frontiers of General Hospital Psychiatry. By 36 contributors. Edited by Louis Linn, M.D. New York, 1961. International Universities Press. Pp. 483. ($10.00)

One of the hopeful signs on the hospital horizon is the increasing willingness of general hospitals to accept mental patients. This reduces the stigma of commitment, makes good psychiatric service available for surgical and obstetrical cases, assures a high proportion of general hospital bed usage, makes it easier for visitors, enriches the training opportunities for interns, residents and nurses, provides wonderful research potentials and makes the hospital a true community health center.

In this collection of 37 short papers, Linn has assembled a refreshing collection of practical ideas on general hospital psychiatry. Organization, medicolegal, and architectural problems are reviewed. The role of the psychiatrist is assayed, the relationship between the psychiatric and the other services is explored, night and day units are explained, and the ways in which the service can contribute to research and training are pointed out. There is discussion of social work, of fitting mental patients into general wards, of the special problems presented by addicts and of what is going on elsewhere in the world. As always in an anthology, there is considerable variation in the quality of the various papers. All chapters are short, however, and if one does not satisfy the reader, it is soon done with, and the next one will. In general, the material is reality-oriented, practical and concisely written. This should be a useful reference work for many years to come, and it will long be a handy guide to any physician professionally or administratively interested in psychiatric services in general hospitals.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

MARCH, 1962 • VOL. XXXV, NO. 3

CHRONIC BRONCHITIS IN GREAT BRITAIN

General practitioners participated in a project to find out the prevalence of chronic bronchitis. Among the findings were that the condition is more prevalent in urban than in rural areas in smokers than nonsmokers, in those less favored economically than in the better off.

Chronic bronchitis presents general practitioners with one of their most frequent and intractable problems. Although palliative treatment is possible and often rewarding, prevention should be the aim; and in a disease of such insidious onset, general practitioners may have to carry the main burden. To advise and treat effectively patients with early bronchitis they need more detailed knowledge of the nature and etiology of the disease than any single experience can provide. Thus, the Research Committee of the College of General Practitioners of Great Britain in 1957 formed a small group to plan and execute a series of investigations into chronic bronchitis. This paper presents preliminary epidemiologic findings.

The excessive mortality from bronchitis in industrial areas and in poorer families is well known, and some studies have suggested a close relationship between air pollution and chronic bronchitis. Both these conclusions, however, derive from certificates of causes of disability or death usually given by general practitioners, so that the apparent social or geographical patterns might reflect differences between doctors in diagnostic habits and standards of certification.

A National Survey Carried Out by the Respiratory Diseases Study Group of The College of General Practitioners, *British Medical Journal*, October 14, 1961.

PLAN OF SURVEY

The present survey was conducted by general practitioners, using a standard clinical questionnaire, to find out the frequency of specified respiratory symptoms in a randomly selected sample of their patients. One of the objectives was to compare the prevalence of "chronic bronchitis" in various population groups with the distribution of mortality and morbidity on routine vital statistics and with the pattern based on a standard diagnosis derived from defined items in the questionnaire. Another objective was to relate clinical assessments and a physiological test of respiratory disability to such variables as age, sex, smoking habits, and place of residence.

Previous mortality and morbidity studies suggest that the age group 45-64 is of crucial importance in the evolution of chronic respiratory disease. Samples were therefore drawn by the Ministry of Health of all men and women on the practicing lists of participating doctors in each of the five years from 40 to 44, 45 to 49, 50 to 54, 55 to 59, and 60 to 64.

Ninety-two practitioners expressed a willingness to take part. The survey was conducted among 1,569 persons (787 men and 782 women). The wives of 442 men selected were also interviewed.

In the absence of any agreed definition of

bronchitis in symptomatic terms, each practitioner was asked to note whether he thought that the patient suffered from chronic bronchitis, asthma, or any other chest disease. The records were then divided into "bronchitis" and "others." Three criteria were used for "standard diagnosis" of bronchitis—morning phlegm in winter, attacks of cough and phlegm lasting three weeks over the past two years, and breathlessness when walking.

The prevalence of chronic bronchitis was 17 per cent in the men surveyed and 8 per cent in the women. In younger subjects, chronic bronchitis was diagnosed almost as often in the women as in the men. Beginning with the 45-49 group, the data show that in men there is a steady increase with age of approximately 1 per cent per year. The age gradient for women is much less steep. The prevalence of chronic bronchitis diagnosed in males is nearly twice as great in urban as in rural areas.

The difference in bronchitis mortality between the urban and rural areas is of about 2 to 1 in men and less in women. On the other hand, when the "standard diagnosis" rates are compared, the rural-urban gradient in males becomes much steeper, and there is a suggestion of an increased prevalence among females in the larger cities compared with the other areas. Thus differences in diagnostic habits between doctors may tend to conceal urban-rural contrasts in morbidity and mortality statistics based upon their certificates.

SMOKING AND SOCIAL FACTORS

In relation to smoking, the prevalence of bronchitis ranged in men from 6 per cent for nonsmokers to 18 per cent among smokers and, correspondingly, from 5 per cent to 12 per cent in women.

It is difficult to make valid comparisons between the two sexes in the prevalence of bronchitis in relation to smoking, for there are too few nonsmoking men and too few heavy-smoking women. However, it was obvious that the prevalence of chronic bronchitis is very similar among men and women with comparable smoking habits except for a higher prevalence among male smokers who on the average smoked more than the female smokers.

In both sexes, there was an upward trend in bronchitis prevalence with descending socio-economic conditions. At ages 45 to 64 the rate for men rose from 199 per 100,000 in what was designated as Group I, consisting of patients in the most favorable socio-economic situation, to 1,048 per 100,000 in Group V, at the other extreme. For women, it rose from 35 per 100,000 in Group I to 87 per 100,000 in Group V.

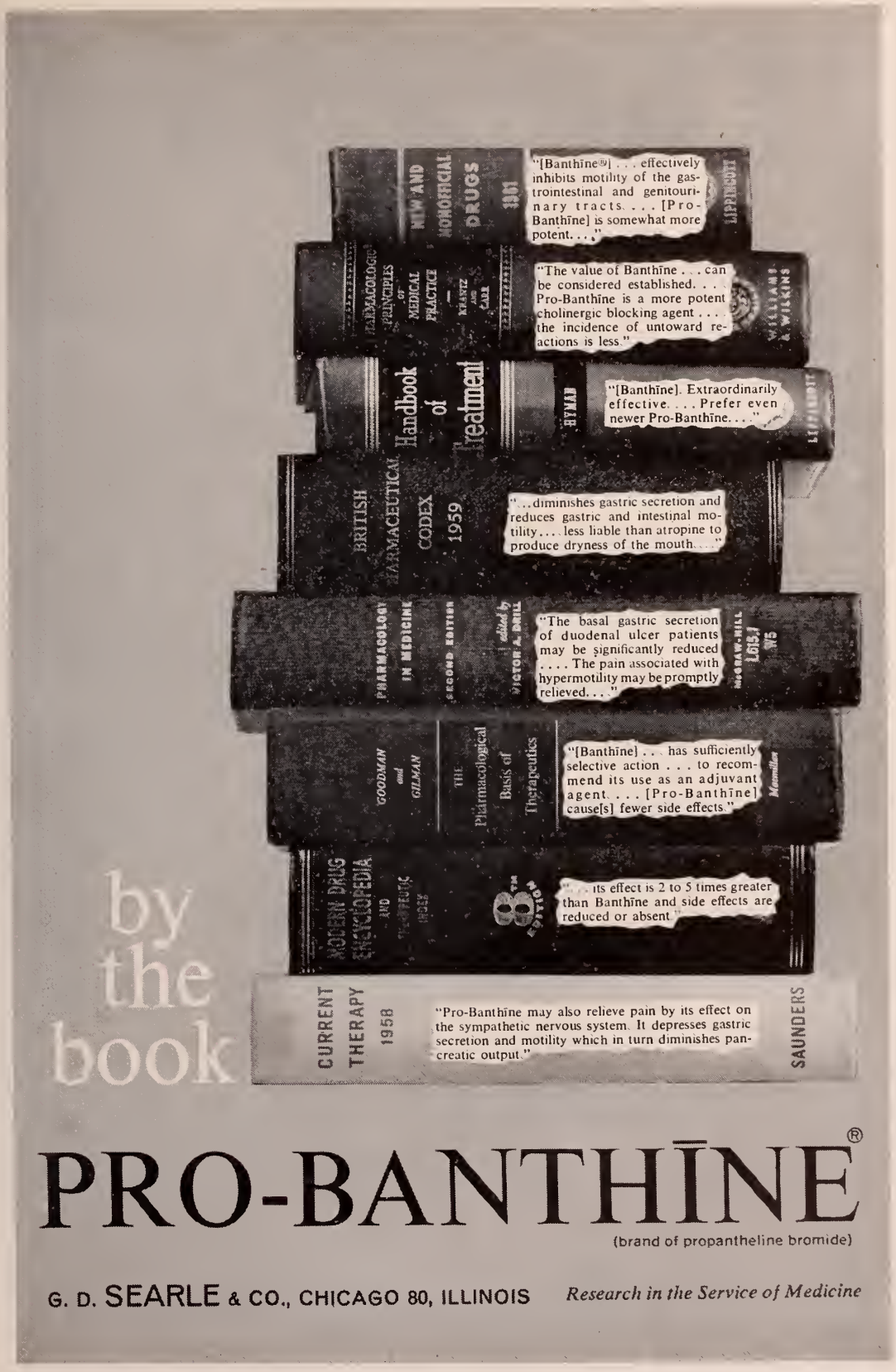
DISCUSSION

Impaired ventilatory capacity was effectively demonstrated by general practitioners using a simple test of respiratory function. The levels they obtained were consistently lower than those obtained by trained workers, but the trends in relation to age, sex, and smoking habits in men were consistent with those of the others.

The patterns of the distribution of chronic bronchitis prevalence based on practitioners' diagnosis are in broad agreement with those given by a "standard diagnosis" based on the presence of defined symptoms. In whichever of those two ways it is defined, chronic bronchitis as found in this survey shows the same relationship to age, sex, social class, and place of residence as the mortality or morbidity rates for this disease recorded in the national vital statistics.

If this sample can be taken as fairly representative of the country as a whole, the striking social pattern seen in mortality data is reflected in morbidity, and these social-class differences in prevalence cannot be attributed to differences in smoking habits. Here again standardization of diagnosis has emphasized the importance of the social-class gradient in the disease. The sex difference, on the other hand, may be largely due to the divergence in smoking habit.

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1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]

3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition. National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6 Overholser W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition J. B. Lippincott, Philadelphia, 1954, p. 264

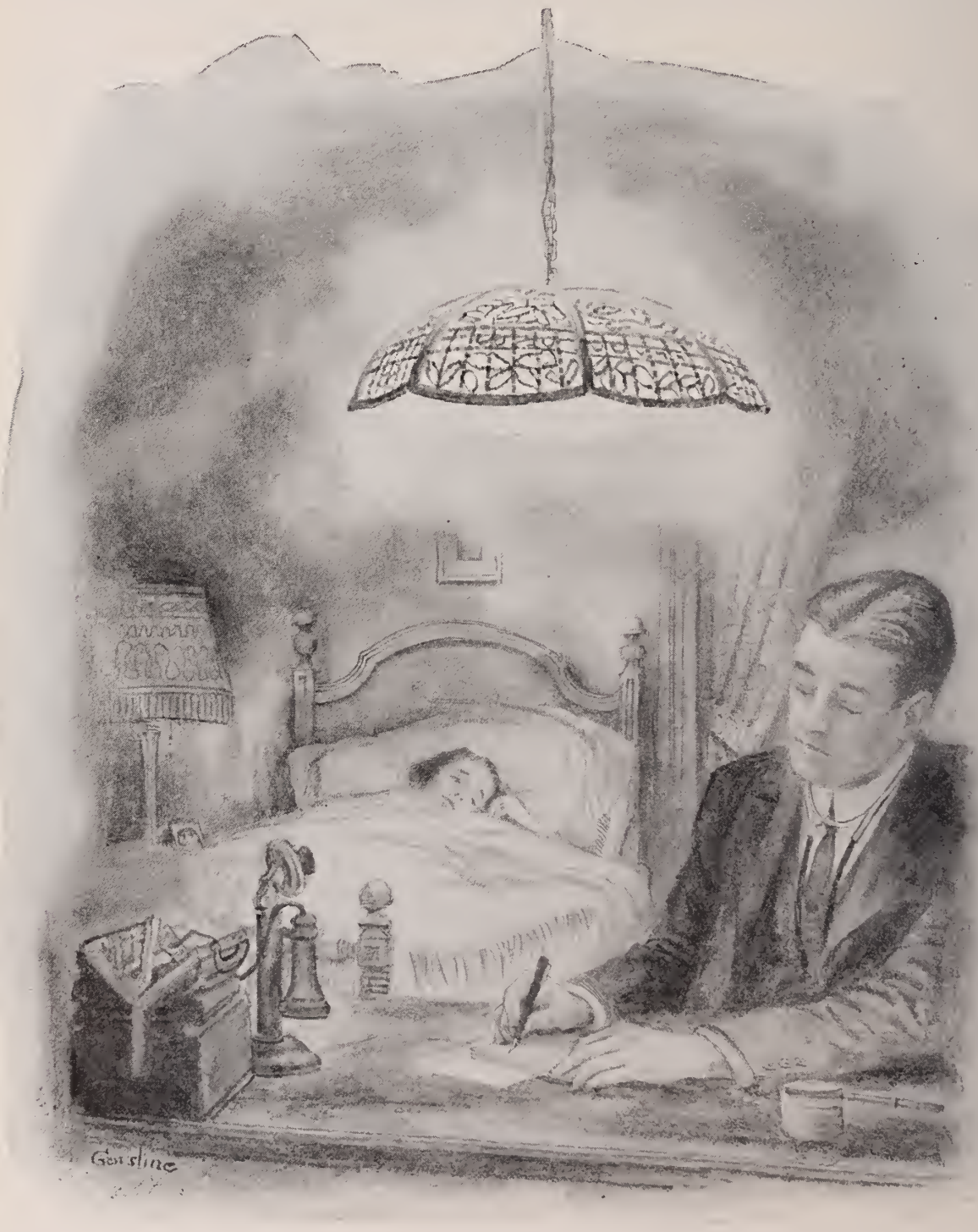
infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7 Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:772 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]

8. Duncan G. G.: Diseases of Metabolism 4th edition W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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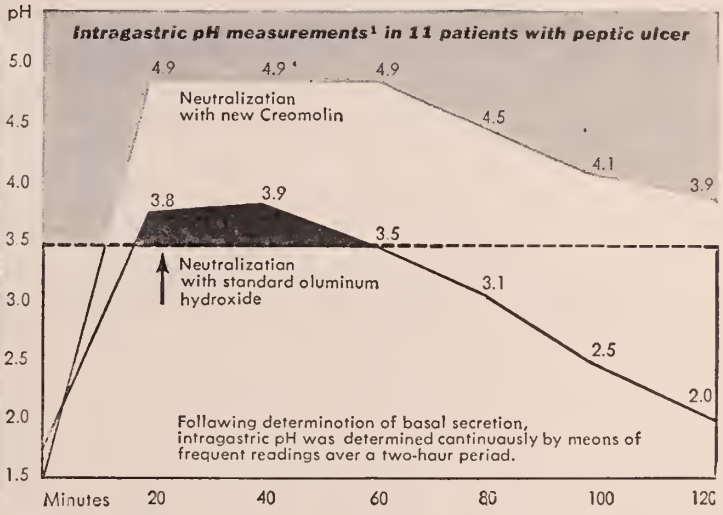
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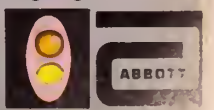
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COSMETIC SURGERY is covered, if the condition to be treated is a result of injury sustained while the Covered Person is insured.

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NO SPECIFIC LIMIT on number of days in hospital or for professional nursing expense.

WORLDWIDE COVERAGE.

THE EXCLUSIONS:
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Full Details of Coverage Are in Policy

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1. King, J. C.: Int. Rec. Med. 172:669 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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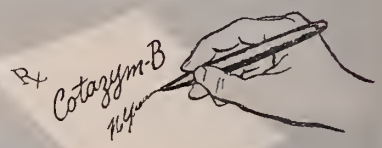
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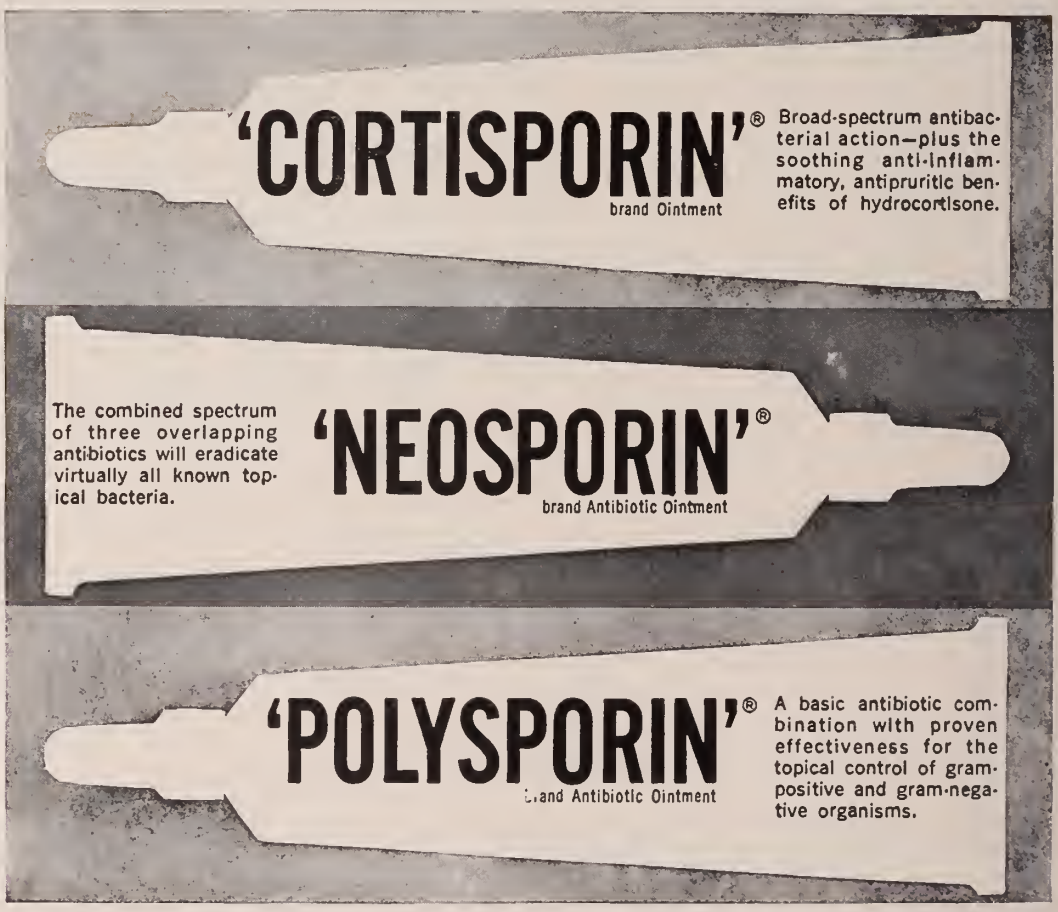
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Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

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Simon, F. G. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 32-37, Jan. '61.

Plotz, M.: "Modern Management of Obesity," J.A.M.A., 170:1513 - 1515 (July 25) 1959.

Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med., 907-920, May '61.

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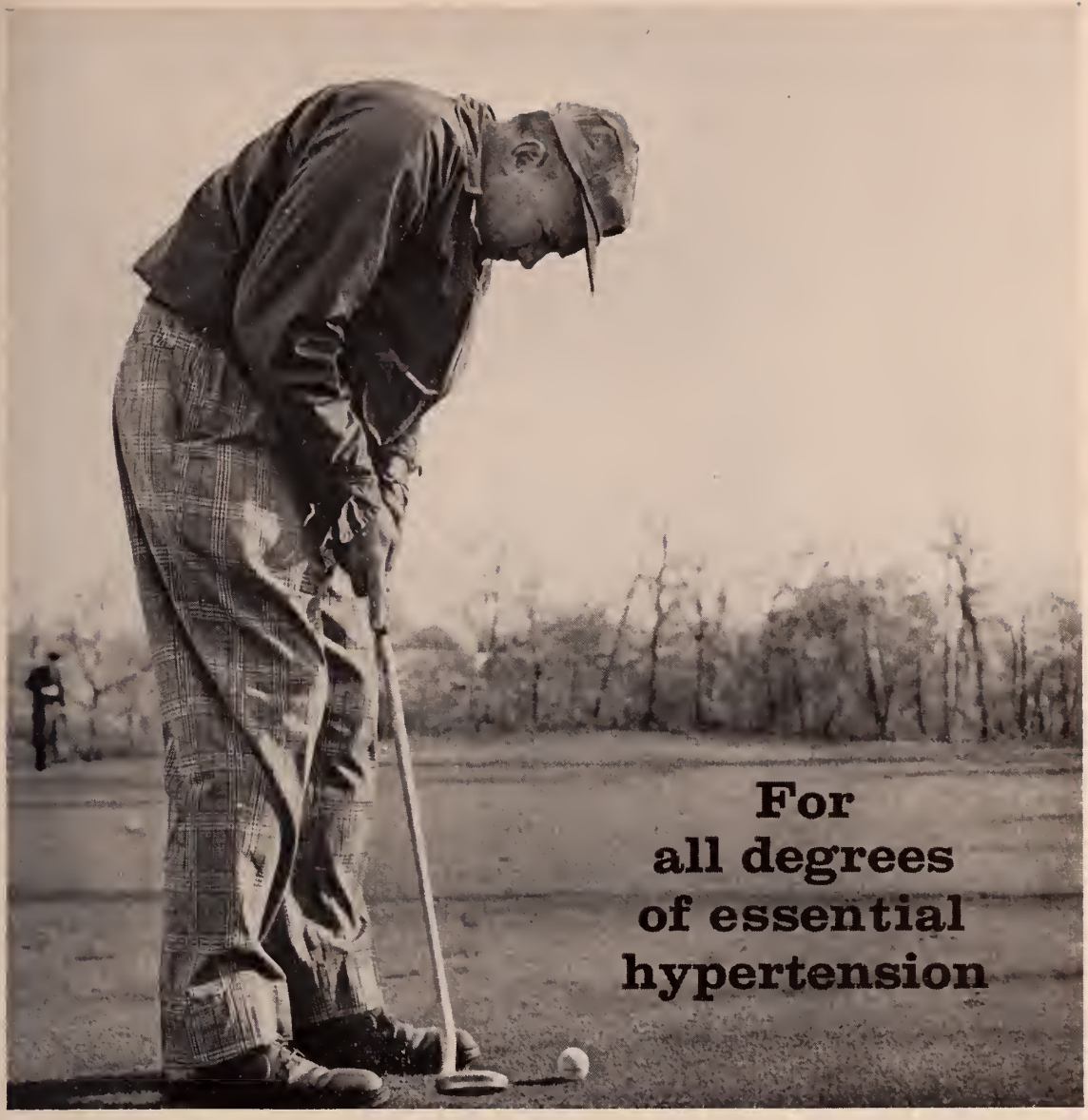
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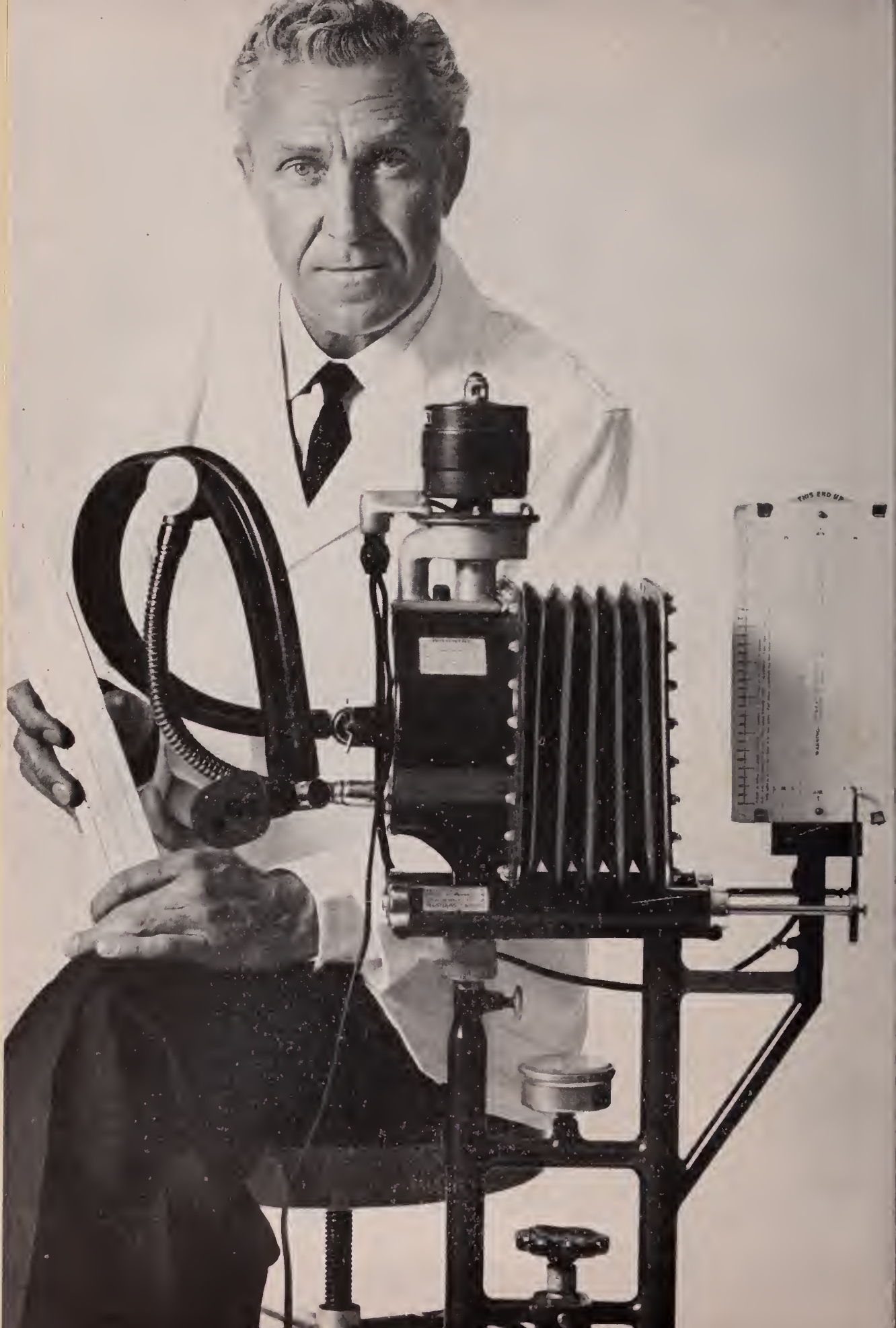
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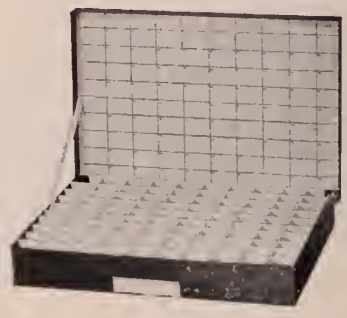
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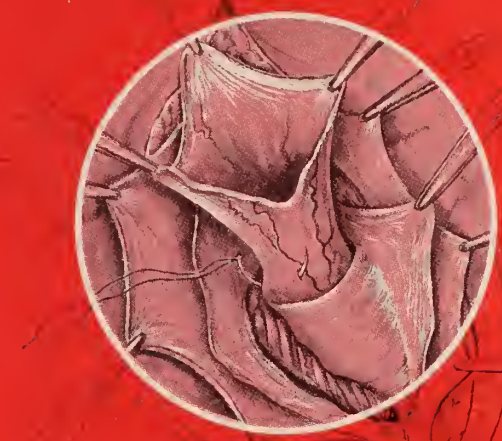
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1. Teitel, L. H., *et al.*: Indust. Med. *29*:150, 1960. 2. Billow, B. W., *et al.*: Southwestern Med. *41*:286, 1960. 3. Beck, C., *et al.*: Clin. Med. *7*:519, 1960. 4. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960.

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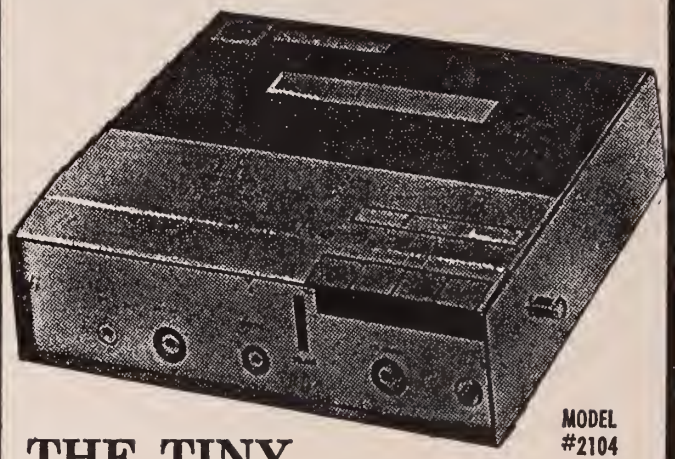
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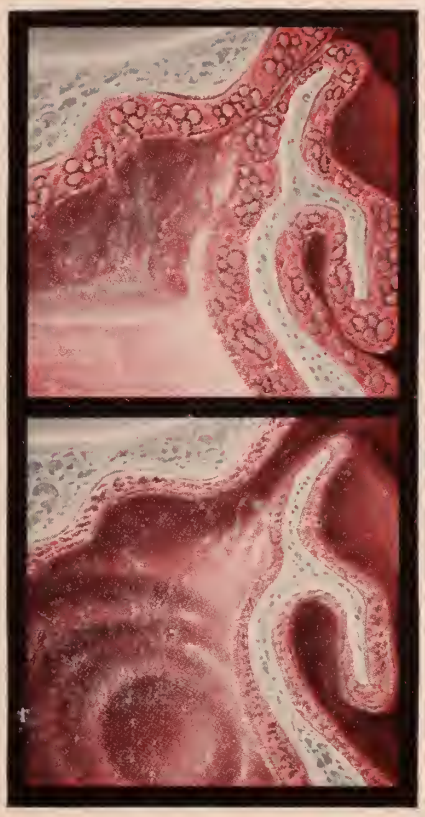
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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References: 1. DeNyse, D. L.: M. Times 87:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. 2:1 (Jan.) 1960.

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"nutrition...present as a modifying or complicating factor in nearly every illness or disease state"[1]

1. Youmans, J. B.: Am. J. Med. 25:659 (Nov.) 1958

cardiac diseases "Who can say, for example, whether the patient chronically ill with myocardial failure may not have a poorer myocardium because of a moderate deficiency in the vitamin B-complex? Something is known of the relationship of vitamin C to the intercellular ground substance and repair of tissues. One may speculate upon the effects of a deficiency of this vitamin, short of scurvy, upon the tissues in chronic disease."[2] 2. Kampmeier, R. H.: Am. J. Med. 25:662 (Nov.) 1958.

arthritis "It is our practice to prescribe a multiple vitamin preparation to patients with rheumatoid arthritis simply to insure nutritional adequacy . . ."[3]
3. Fernandez-Herlihy, L: Lahey Clinic Bull. 11:12 (July-Sept.) 1958.

digestive diseases Symptoms attributable to B-vitamin deficiency are commonly observed in patients on peptic ulcer diets.[4] Daily administration of therapeutic vitamins to patients with hepatitis and cirrhosis is recommended by the National Research Council.[5] 4. Sebrell, W. H.: Am. J. Med. 25:673 (Nov.) 1958. 5. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition National Academy of Sciences and National Research Council, Washington, D. C., 1952, p. 57.

degenerative diseases "Studies by Wexberg, Jolliffe and others have indicated that many of the symptoms attributed in the past to senility or to cerebral arteriosclerosis seem to respond with remarkable speed to the administration of vitamins, particularly niacin and ascorbic acid. These facts indicate that the vitamin reserve of aging persons is lowered, even to the danger point, more than is the case in the average American adult."[6] 6. Overholser, W., and Fong, T.C.C. in Stieglitz, E. J.: Geriatric Medicine, 3rd edition, J. B. Lippincott, Philadelphia, 1954, p. 264

infectious diseases Infections cause a lowering of ascorbic acid levels in the plasma; and the absorption of this vitamin is reduced in diarrheal states.[7] 7. Goldsmith, G. A.: Conference on Vitamin C. The New York Academy of Sciences, New York City, Oct. 7 and 8, 1960. Reported in: Medical Science 8:72 (Dec.10) 1960.

diabetes Diabetics, like all patients on restricted diets, require an extra source of vitamins.[8] "Rigidly limiting the bread intake of the diabetic patient automatically eliminates a large amount of thiamin from the diet. . . . There is some evidence of interference with normal riboflavin utilization during catabolic episodes."[9]
8. Duncan, G. G.: Diseases of Metabolism, 4th edition, W. B. Saunders, Philadelphia, 1959, p. 812. 9. Pollack, H.: Am. J. Med. 25:708 (Nov.) 1958.

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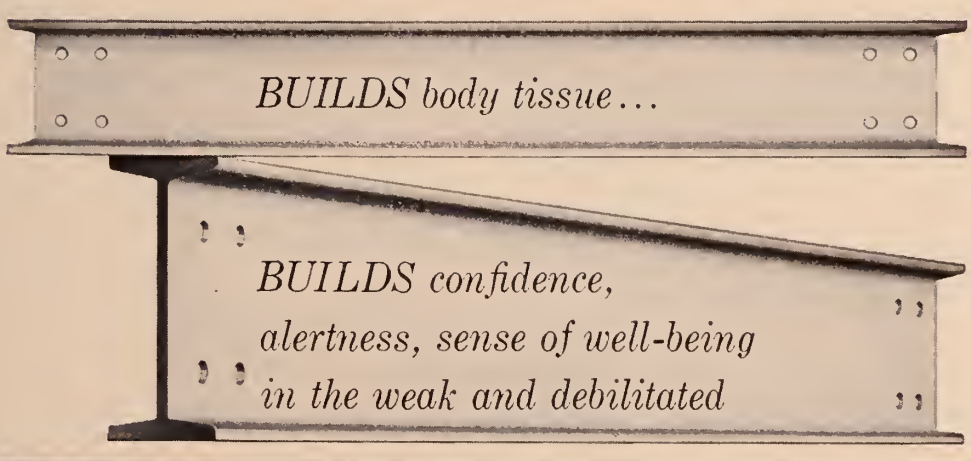
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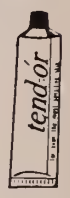
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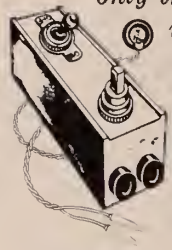
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*Schaefer, L. E.: Clin. Med. 8:1343, 1961.

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THE JOURNAL
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Editorials • • •

The Illegal Sale of Samples

In 1961, millions of physicians' sample drugs in the possession of persons who secured them from physicians (to resell them) were seized and impounded by the Federal Food and Drug Administration and New Jersey State Department of Health. The New Jersey actions followed quickly upon the prosecution of makers and distributors in a national counterfeit drug ring operating out of New Jersey based on evidence secured through the cooperative efforts of the New Jersey State Department of Health and the New Jersey State Police.

The seizures of repackaged physicians' samples by the Federal Government and the embargoes by the State Department of Health in New Jersey are based on laws governing adulterated and misbranded food and drugs. Seizures and embargoes were made by both federal and state agencies at four establishments in New Jersey: one in Leonia, one in Newark, one in Fort Lee, and one in Iselin. Action was taken by two drug sample owners to release the seized drugs. The U. S. District Court held that the seizure was proper in all cases where physicians' samples had been repackaged. During the trial of one case, Judge Arthur S. Lane commented as follows: "The petitioner is a wholesaler and distributor of articles of drugs, selling exclusively to retail drug stores. In an affidavit he makes the amazing disclosure that 'over 90 per cent of the income of my business has depended for many years on the purchase from physicians of samples and the sale of said items to drug stores.' It is this Court's understanding that drug companies distribute complimentary physician samples to publicize their drugs, to permit doctors and patients to become used to their application, and to aid those unable

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to afford the price of these drugs. The sale of physician samples to a drug repacker and wholesaler who, in turn, sells to retail pharmacists is a matter that I hadn't known existed, and I don't want to characterize it without further proofs; but it is, at best, a most interesting situation."

The court stated that one of the patterns developed during the trial related to cases "where the wholesaler buys complimentary bottles of pills from several physicians and then he or the doctor repackages the pills from the complimentary bottles into a larger commercial bottle. It is understood that the commercial bottle label correctly describes the pills it holds, and it contains no marking of the fact of 'Complimentary Package'."

Clearly, the practice of buying and selling physicians' samples creates a risk of repacking. If repacking occurs, there is a change in the original label, and a resulting loss of a control number on the drugs as originally given to the individual doctor by the manufacturer. Additionally, there is a hazard to public health and a violation of the statutes relating to cleanliness and quality control of food and drug products. In considering this problem the court stated "if repackaging occurred, whether done by a doctor or the wholesaler, the repackager destroys the system of close control maintained on the manufacture and distribution of drugs. For example, the wholesaler could buy a bottle of Pill X from several doctors, and then all the Pills X could be transferred to one large bottle. Now this large bottle could correctly describe the ingredients of Pill X on its label. But when the original label of the sample bottle was removed or no longer used, the control number of that particular lot would be lost and subsequently different lots of Pills X are mixed.

"The control numbers are important components of a control system. They help to identify a specific unit of drug produced and bring together all the control data about the manufacture and distribution of a specific unit of drug. 'In effect, the control number is the key to the history of the drug,' states Dr. Frank H. Wiley, Director of Pharmaceutical Chemistry, U. S. Department of Health, in his affidavit before this Court. Dr. Wiley further states in his affidavit: 'If a batch of a drug after marketing produces adverse or harmful effects or is ineffective or otherwise defective, code numbers permit an easy segregation of such a drug for prompt recall from the market or destruction purposes before harm to the public from its use becomes widespread.' When repackaging occurs, different expiration dates of the same pills are mixed. And with the resulting loss of control numbers on a particular lot, the manufacturer would be unable to trace an overpotent dose of pills, or any dose of pills that was deficient in any regard."

The Judicial Council of The Medical Society of New Jersey has concluded "that the selling of these samples by physicians to any person or agency is both unethical and unprofessional, not only because of the utilization of these free samples for unintended and indefensible personal gain but because the entrusting of them to the custody of any person other than a physician would expose the ultimate user to the dangers of employing pharmaceuticals that are out of date and therefore scientifically undependable." In a letter dated September 13, 1961, directed to physicians, pharmacists and pharmaceutical manufacturers regarding repackaging of physicians' samples, the State Commissioner of Health urged that necessary control procedures be instituted immediately to insure that physicians' samples were used only by physicians in their professional practice. That letter pointed out that many such samples had been embargoed and additional embargo actions were being considered.

It is hard to believe that anyone worthy of the title "doctor" or a license to practice the most vital of all professions, would engage in such a shabby practice to pick up a few ill-earned dollars. Some physicians may have agreed to market their samples as an alternative to throwing them away, without realizing the shameful implications of this action. Let them think of it now. *Verbum sap!*

AMA's New Meeting Place

Physicians attending the June 24-28 session of the American Medical Association in Chicago will view 700 exhibits and hear scientific papers in the air-conditioned comfort of America's most modern exposition center—"McCormick Place." If you attended the last Annual Meeting held in Chicago (in 1956) you have unpleasant memories of humid weather and poor facilities on the old Navy Pier. This time you will visit the new $34,000,000 convention "city" on the lakefront which boasts unobstructed exhibit areas, theatres, attractive restaurants and lounges, shops, and esplanades.

"McCormick Place" is a huge, horizontal structure three blocks long, a block wide and equal to a ten-story building in height. It is fully equipped to handle 30,000 people an hour as they visit exhibits.

There is ample parking for everyone in huge lots adjoining the building. "McCormick Place" is a ten-minute taxi or bus ride from the hotel area in the Loop.

Hotel rooms will be available for everyone. There are 45,700 hotel rooms for guests in the central Chicago area, plus more than 100 hotels in and around the city.

The 1962 meeting will be the first in recent history in which it will be possible to house the entire meeting—scientific sessions, scientific and industrial exhibits, section meetings—under one roof.

Mail Order Medication

As physicians, we scorn diagnosis or treatment through the post office. A similar attitude should lead us to question the filling of our prescriptions by mail order. The postal pharmacist must either assume that the signer of the prescription is an authorized physician; or he has to invest time, expense and trouble in finding out. If the drug retailer is in another state, he is immune to the safety regulations governing dispensing in the doctor's own state. Even the speediest postal service is slower than the traditional over-the-counter method. Every medical practitioner has had occasion to thank some pharmacist for calling him up to verify a dosage or a drug name. This kind of courtesy—or precaution—is impossible by remote control. The reciprocally helpful relations between physician and pharmacist will never flourish when their only bond is a postage stamp. You do not know anything of the professional qualifications of the man who fills the prescription in a distant state. It is almost impossible to check on errors, brand substitutions or other sources of dissatisfaction by a postal complaint, whereas the local pharmacist is there, and is going to be there quite a while. If the mail order pharmacist can charge less, it is only because he can fill prescriptions in such huge quantities as to make lower prices economically possible. But here is one area where a belt-line, mass-production operation is not desirable.

The patient may not ask us—or tell us. But if he does, we ought to remind him that there is a real advantage in having a neighborhood pharmacist who maintains prescription files and gets to know the patient and the doctor. No one knows whether mail order drugs are really cheaper. Even if they are, cheapness is not our prime requirement here. Some things are more important than price.

Trustees' Meetings

DECEMBER 17, 1961

Among the activities at the December 17, 1961 meeting of the Board of Trustees were the following:

These appointments were announced:

Joint Planning Committee for Progressive Patient Care Workshop—(with New Jersey Hospital Association)
Jerome G. Kaufman, M.D.
Marcus H. Greifinger, M.D.
Louis S. Wegryn, M.D.

Special Committee on State Employees and Workmen's Compensation
Joseph A. Lepree, M.D., as third member of committee to serve with Dr. Greifinger and Dr. Ruoff.

Special Committee on Membership Directory
Marcus H. Greifinger, M.D., Chairman
Louis S. Wegryn, M.D.
John J. Bedrick, M.D.
Nicholas A. Bertha, M.D.
Richard I. Nevin, Executive Officer, *Ex-Officio*
John P. Hartzell, Office Manager, *Ex Officio*

Special Committee on Hospital Staff Appointments
Nicholas A. Bertha, M.D., Chairman
Louis S. Wegryn, M.D.
Luke A. Mulligan, M.D.
Ralph M. L. Buchanan, M.D., President, *Ex-Officio*
Richard I. Nevin, Executive Officer, *Ex-Officio*
Robert M. Backes, Counsel, *Ex-Officio*

The Board received, noted and filed an announcement from the American Medical Association to the effect that on June 1, 1962, the American Medical Education Foundation would consolidate with the American Medical Research Foundation.

EYE HEALTH AND CONSERVATION OF VISION

Following review of 1961 statistics, the Special Committee recommended, and the Administrative Council on Public Health approved, the following procedures to augment the existing program, and approved procedures for improvement of future programs:

1. County chairmen of committees on the conservation of vision to get copies of all literature and materials sent to the State committee.
2. County chairmen to be included in the overall program in a cooperative capacity. The physicians-in-charge will still direct their own programs. The county chairmen, after contacting the physicians-in-charge in their respective counties, can help promote the program and coordinate the participants and publicity where local programs seem *not* to to be functioning properly.
3. Opticians will help publicize the program with newspaper ads, etc., if requested.
4. Invite the Veterans Hospitals to participate in the program and designate the chief ophthalmologist in each V.A. hospital as the physician-in-charge.
5. Have more centers conduct the program during evening hours, particularly in those areas where there is pressure or indication that the program should be conducted with some evening hours.
6. All statewide publicity is to be handled through the Council on Public Relations of The Medical Society of New Jersey, or with the cooperation and/or approval of that council.
7. Restore to the program proclamation by Governor for annual Eye Health Week.
8. Obtain local proclamation through community officials.

Points one through eight were approved. A ninth point, "Publicity posters in physicians' offices" was deleted, since such posters would not warrant the extra cost involved.

It was the *recommendation* of the special committee, approved by the council:

> That the statistical report on the 1961 Eye Health Screening Program be submitted to THE JOURNAL with the request that the full report, including the individual center statistics, be published in an early issue.

This was amended to read that the full report be published "if feasible." The amended recommendation was approved.

County chairmen of Committees on Conservation of Vision have indicated interest in the activities of the state committee and would like to have more information on the program and activities of the state committee.

The special committee *recommends*, and the council approves:

That annually the state committee hold a joint meeting with county chairmen to bring them up to date on the activities of the state committee and to explain how the county committees can assist in the state program.

The recommendation was approved.

On invitation of the special committee, 115 ophthalmologists in New Jersey have indicated their willingness to participate in the school vision program. The following have been developed as the next step:

1. Establish contact with the New Jersey State Department of Education, through Dr. Geoffrey W. Esty, and request that Department's cooperation.
2. Depending on local conditions, request the assistance of the school administrator — or request the school physician to approach the school administrator if that seems advisable. In areas where direct approach is not feasible the workshop committee must devise its own approaches for the institution of the program.
3. Base the workshop program on the committee's booklet "Referral of School Children for Eye Care."
4. Suggested workshop audience—school personnel: nurses, physicians, administrators, councilors, psychologists; and Presidents of P.T.A.s.

The Council on Public Health reaffirmed its endorsement of the school vision program in general and approved the above four points in particular. It is *recommended*:

That the above four points be approved as the next step in the program. This was approved by the Board.

In a communication from Commissioner Kandle concerning eye bank facilities in New Jersey, it was stated that while it appears that New Jersey is well served by New York and Philadelphia, a change in law could facilitate getting New Jersey's fair share of specimens. In New Jersey, legislation was enacted in 1954 (Chapter 113, Title 26) referring to necropsy and postmortem examinations, but no statements there permit removal of tissues for use in another person; so that it is necessary for separate permission for this to be obtained besides the regular autopsy permit. Further, if one wills his eyes for scientific purposes, removal can still be denied by the next of kin. Ophthalmologists and the boards of eye-banks are interested in corrective legislation but so far none has been proposed.

The Board of Trustees, on recommendation of the Council and special committee endorse legislation to permit removal of eyes for eye banks.

The council and Board approve the action of the special committee and *recommend*:

That the matter be referred to the Council on Legislation; and that Commissioner Kandle be kept informed of any developments on the issue.

AUDIT REVIEW

The committee on Audit Review met and surveyed the Treasurer's books for the fiscal year ending May 31, 1961. All questions about the audit were satisfactorily answered. The committee and the Board of Trustees approved the auditors' report.

AIR POLLUTION

The Board received and noted that a subcommittee of the Council on Public Health had been appointed to serve as an Advisory Committee to the Air Pollution Commission, in accordance with the Board's directive.

PROPOSED RELATIVE VALUE INDEX

Replies from component societies concerning their actions on the proposed Relative Value Index (RVI) indicate that 8 counties approve the proposal, 7 counties disapprove, and the remaining 6 counties have not yet voted on the proposal. The proposal was formally disapproved by Bergen County at a regular meeting. However, the results of a mail poll of the Bergen County members showed that 66 per cent of the returns approved a Relative Value Index (RVI).

Replies from 13 of 16 state societies which have adopted an RVI indicate satisfaction with the operation of the index. The National Association of Blue Shield Plans has adopted a Relative Value Index (RVI).

On the basis of the action of the 1961 House of Delegates which returned the Proposed Relative Value Index for further study for another year by all parties concerned; in view of the reports from component societies and the other state societies; and in view of the action of the Board of Trustees on the previous recommendation of the Council on Medical Services, it was agreed that the Proposed Relative Value Index for New Jersey should be

publicized; that a mail poll of the membership should be taken between now and May 1962; and that a full report be presented to the 1962 House of Delegates for final action. The following recommendations were unanimously adopted for presentation and consideration by the Board of Trustees:

a. That a brief article prepared by Dr. Klompus be published in THE JOURNAL.*

b. That component societies be requested to publish material based on the JOURNAL article, or items calling attention to the JOURNAL article, in their monthly *Bulletins.*

c. That a mail poll of the membership be taken following the publicity activities to determine the overall reaction to the proposed Relative Value Index for New Jersey.

It was the unanimous action of the Council on Medical Services that the Trustees be requested to approve these recommendations in view of the vast amount of work done on this project in the past four years. The council pointed out that the publicity and mail poll would be relatively inexpensive in comparison with the time and energy expended by the council over the years in studying this assigned project. Cost of the mail poll would be approximately $750. The major portion, if not all, of this cost would be available in the current budget allotment to the council. The council requested that this be brought to the attention of the Trustees.

Recommendations a. and b. were approved. The following was added to recommendation c: that the results of the poll not be accepted unless there are returns from a majority of the general membership; that returns be separated by counties; that county societies be advised of the votes. Dr. Allman opposed a mail poll, stating that the returns would not warrant the expense.

INDUSTRIAL HEALTH

Received and noted was the following report on the activities of the Special Committee on Industrial Health:

From its meeting on November 19, 1961, the Special Committee on Industrial Health detailed plans for its exhibit at the 1962 annual meeting. The Council on Medical Services noted that the special committee was considering as an exhibit item a medical evaluation form which is now being used experimentally by New York cardiologists in cooperation with the New York Heart Association. This form when completed is submitted to the employer to evaluate the type of work a cardiac-employee is limited to do.

It was the opinion of the council, since the Special Committee on Workmen's Compensation is studying evaluation of permanent impairment, and currently concentrating on cardiac impairment, that the New York form should not be an exhibit item unless and until cleared through the Special Committee on Workmen's Compensation. With the consent of the council, the chairman directed that Dr. Caldwell be notified by letter of the council's opinion on this matter.

EYE CARE BENEFIT FORM

Referred to the Council on Medical Services from the Secretary of the Society was a communication from a member requesting advice concerning signature on a form utilized by union members for optical care benefits. The form contains the following statement, which the physician is requested to sign:

"I hereby authorize the Trustees of Local Blank or its representatives to examine all records pertaining to the examination of the above patient, and do further certify that the patient appears above is the patient who received services."

It was noted that the statement was incorrectly worded, and should read ". . . certify that the patient *whose name* appears above is the patient who received services."

In his letter of referral, the Secretary pointed out that the statement does breach the doctor-patient relationship as it relates to information about patients. It was his feeling that this should be brought to the attention of the Welfare Fund directly. It was the unanimous opinion of the council that the physician-member was not compelled to sign any form, but that he could type his name in the designated space and have his patient sign the form, thus the authorization to examine the records would be given by the patient and not by the examining physician.

The council directed that the physician-member be notified of the council's opinion.

The opinion of the council on this item was approved. The Welfare Fund will be informed of the Board's action and of the error in the wording on the form.

Dr. Kaufman moved—seconded by Dr. Greifinger, and carried—that the report as a whole as amended be accepted.

*This appeared on page 100 of the February 1962 issue of this JOURNAL.

A Symposium on Child Safety, sponsored by the Special Committee on Child Health, is being scheduled for April 7, 1962 at the Presbyterian Hospital in Newark. Participants will be from the State Department of Education, New Jersey Congress of Parents and Teachers, New Jersey State Safety Council, New Jersey Chapter of American Red Cross, Boy Scouts of America, and New Jersey Chapter of the American Academy of Pediatrics.

The following *recommendation* of the special committee was approved by the Council on Public Health:

That the Governor be requested to name April, 1962 as "Child Safety Month" in New Jersey.

Dr. Greifinger pointed out that the month of April is "Cancer Month." On his motion, the recommendation was amended to request the Governor to name "the week of April 1-7, 1962, as Child Safety Week in New Jersey."

HOSPITAL FORMS

The AMA Committee on Maternal and Child Care has developed a "Guide for the Study of Perinatal Mortality and Morbidity" and a supplement for implementing such studies. The supplement contains the following recommended hospital forms:

(1) Prenatal Record
(2) Obstetrician's Newborn Record
(3) Physician's Record of Newborn Infant
(4) Nursery Record of Newborn Infant
(5) Newborn Nursery—Daily Worksheet

The AMA committee has requested the cooperation of medical societies in promoting "standard hospital forms for use in obstetrical departments of hospitals."

The following *recommendations* of the special committee were approved by the council:

(1) That it be recommended to the AMA Committee on Maternal and Child Care that the Apgar Rating be incorporated in the Obstetrician's Newborn Record (hospital form No. 2).

The recommendation was approved.

(2) That the Standard Hospital Forms, as recommended by the AMA Committee on Maternal and Child Care, with the Apgar Rating incorporated in form No. 2 be endorsed by The Medical Society of New Jersey.

The recommendation was approved.

(3) That it be recommended to New Jersey hospitals that these standard forms be adopted for use in each hospital.

This recommendation was approved.

Standards for obstetrical departments, adopted by the Medical Society in May 1955, were reviewed by the special committee and revised standards were recommended with the approval of the council. The Board directed that Standard No. 9 be amended to include the phrase "at the specific direction of the attending physician."

The Board also directed that the revised standards be distributed to all hospitals in New Jersey. The revised standards follow:

OBSTETRICAL DEPARTMENT STANDARDS

1. All personnel entering the labor and delivery room suite shall wear a clean laundered gown or uniform, and such personnel leaving the delivery room suite shall change to another clean laundered gown or uniform before reentering the suite.
2. Rectal and vaginal examinations should be made only when necessary to guide management of labor and must be recorded. Vaginal examinations should be done only under sterile precautions.
3. Oxytoxics prior to delivery should be ordered only where definite indications exist. Such indications should be recorded on the patient's hospital chart. A physician must be in attendance during the administration of oxytoxics.
4. Consultation with a competent consultant (preferably a member of the obstetrical staff of a hospital approved by the Joint Commission on Accreditation) is mandatory in primary Cesarean Sections.
5. Except for the patient of a fully qualified obstetrician in his hospital, consultation is required in the following situations:
   A. Before Cesarean Section.
   B. When there is a history of previous uterine surgery.
   C. Where induction or stimulation of labor by oxytoxics seems indicated.
   D. In all cases of abnormal vaginal bleeding.
   E. In all cases of prolonged labor or prolonged rupture of the membranes.
   F. In breech or any abnormal presentation.
   G. Before all other operative deliveries except outlet forceps and episiotomy.
   H. In toxemias, diabetes, heart disease, serious medical complications, or surgical complications.
6. A report signed by each consultant must be on the patient's hospital chart.
7. All cases of infection must be isolated from the Maternity Section.

8. House officers should scrub and assist for private as well as for ward deliveries, if possible.
9. A qualified obstetrical nurse should be present at all times in the maternity unit. This nurse should be permitted to perform rectal examinations at the specific direction of the attending physician.
10. Anesthesia should be administered by trained personnel whenever possible.
11. Facilities for suction and for the resuscitation of infants and adults should be available in the delivery room at all times.
12. Facilities should always be available for immediate transfusion.
13. Provision should be made for continuous observation of patients for at least one hour post-partum.
14. Blood types, Rh factor, and serology should be recorded on the patient's hospital record before delivery.
15. Cord blood should be taken for appropriate tests in all cases where blood incompatibility may exist.

MENTAL HEALTH

The special committee pointed out that the report of the nationwide Joint Commission on Mental Health and Mental Illness (published under the title of *Action for Mental Health*) has been widely publicized. It is being vigorously discussed by numerous groups. Purpose of the report "is to arrive at a program that would approach adequacy in meeting the needs of the mentally ill—to develop a plan of action, in other words, that would satisfy us that we are doing the best we can toward their recovery."

Many physicians do not know how controversial the report is. It is the opinion of the committee that the report should be kept in proper perspective. The report has received widespread recognition and has been read by many lay people. It is being studied by many organizations for the purpose of offering suggested revisions. Caution should be used in applying any aspect of the report without first consulting with the proper professional organization.

It is *recommended* by the special committee and approved by the Council on Public Health and the Board:

That an item concerning the report "Action for Mental Health" be published in the *Membership News Letter* and/or THE JOURNAL.

MEDICARE

Dr. Bertha reported that supplemental agreement number 3203 had been received from Washington for execution by the proper officials. It provides instructions regarding invoicing, IBM card and machine listing preparation, adjustment and supplemental billing procedure, and "complete" claim advice under an operational situation where both the current and revised claim forms are in use by physicians and dentists.

The supplemental agreement has been executed by officials of MSA; and the Board directed that the proper officials of the Medical Society be authorized to execute the agreement.

DISASTER MEDICAL SERVICES

As the Society's representative, Dr. Betts reported he had attended the AMA "Training Workshop on Medical Self-Help" in Brooklyn, October 17 to 19, 1961. The Department of Defense and the United States Public Health Service have developed a plan for a medical self-help training course to prepare the American people to take care of their own physical needs and injuries in the event of atomic war. The plan has AMA approval.

Dr. Betts displayed a kit to be used by instructors. It includes film strips and instruction pamphlets. The Public Health Service does *not* want physicians to teach the course; it does want medical society sponsorship of the course.

In New Jersey, teachers under the State Department of Education are paid to teach similar courses.

The special committee recommended that we offer to the Department of Civil Defense and Disaster Control, our wholehearted cooperation in sponsoring and implementing the medical self-help training course; and that a letter be addressed to each component society, with a copy to its civil defense chairman, urging wholehearted support of this medical self-help program. The Board approved.

The special committee suggested that Dr. Kandle, State Commissioner of Health and State Medical Director for Civil Defense, be offered the Society's services; and that an early meeting with him and his staff be arranged to assist them in any way appropriate.

With the consent of the Board, the chairman directed that the Special Committee on Disaster Medical Services act as the Society's agent in carrying out the committee's suggestion.

MEMBERSHIP DUES PAID

The Board ordered payment of membership dues: $25 to the New Jersey Welfare Council; and $50 to the U. S. Chamber of Commerce.

RE-EXAMINATIONS TO MAINTAIN LICENSE

The Board had asked the AMA about an item which had appeared in the November 6, 1961 *Medical Economics* concerning re-examination of medical practitioners. The following reply was received from Dr. Howard, Assistant Executive Vice-President of AMA:

> The implied endorsement by Dr. Ruhe of our staff of regular re-examination of practicing physicians for licensure is absolutely incorrect. Dr. Ruhe made no such comment. In fact, the comment was made by the reporter from *Medical Economics* who, in effect, put his words into Dr. Ruhe's mouth. I can say categorically that no committee or council of the American Medical Association is promoting compulsory re-examination of physicians.

A letter will be sent to Dr. Howard expressing the Board's gratitude for his reply, suggesting that AMA request *Medical Economics* to retract the item.

BLUE CROSS OUT-PATIENT ALLOWANCE

The Board had previously reported substantial agreement with the Hackensack Hospital Medical Board on the issue of two follow-up visits after the original emergency room visit under Blue Cross. Mr. Minard, President of HSP, has replied that the Blue Cross contract is not limited to "follow-up" visits in connection with emergency treatment when such emergency was handled without an order from or attendance by, the subscriber's personal physician. It applies to registered eligible out-patient admissions whether an emergency or not. The contract provides services to subscribers in connection with hospital expense. If such subscriber also incurs a physician expense for an eligible service, the Blue Shield contract covers it. Blue Cross should not be held responsible for the situation implied. Rather, this is a situation where the medical staff in cooperation with the hospital administration could by rule provide that follow-up visits should be referred to the patient's attending physician, whether the service is to be performed in the hospital or at the physician's office.

The Board also reported its action to MSP. In reply Dr. Alfano stated that it was the consensus of MSP Board that the issue raised by the Medical Executive Board of Hackensack Hospital should be resolved by the medical staff and the hospital administration, without involvement of either HSP or MSP.

With the consent of the Board, the chairman directed that the two replies be received and noted and that copies of both letters be sent to the secretary of the Medical Executive Board of the Hackensack Hospital and to the president of the Bergen County Medical Society for their information.

REHABILITATION

The Council on Public Health noted with regret that solicitation of funds from the Medical Society toward the initial compilation and publication of a directory of services for the handicapped and the chronically ill in New Jersey was rejected by the Trustees. The council requests that the Board of Trustees reconsider its action. The council also requests the Board to allow Dr. Elias to speak in behalf of the proposal.

Following discussion the Board reaffirmed its previous action of November 19, 1961 that the request for funds be denied.

JANUARY 21, 1962

In accordance with previous Board directive, the following appointments were made and announced at this session:

A. *Association Public Affairs Conference*—Sponsored by the U. S. Chamber of Commerce, January 24-25, 1962, Washington, D. C.

Ralph M. L. Buchanan, M.D., President
Louis S. Wegryn, M.D., President-Elect

B. *AMA Special National Legislative Conference*—January 26-27, 1962, Chicago

Samuel J. Lloyd, M.D., Chairman, Council on Legislation
Mr. Richard I. Nevin, Executive Officer

C. *AMA 8th Annual Conference on Mental Health*—February 2-3, 1962, Chicago

Robert S. Garber, M.D., Chairman, Committee on Mental Health

D. *Hospital Survey Team*
John J. Bedrick, M.D., Chairman
Carl A. Maxwell, M.D.
Thomas J. White, M.D.

E. *Advisory Panel to Director of Motor Vehicles*
Jerome G. Kaufman, M.D., Chairman
Jesse McCall, M.D.
Louis F. Albright, M.D.

SELECTIVE SERVICE COMMITTEE

President Buchanan reported that, from the nominations submitted by the Society, the National Committee had appointed Dr. McCall to the chairmanship of the New Jersey Advisory Committee to the Selective Service System to succeed Dr. Herrman.

CONGRESS ON MEDICAL EDUCATION AND LICENSURE

The AMA Council on Medical Education and Hospitals, the Federation of State Medical Boards, and the Association of Hospital Directors of Hospital Education will meet in Chicago on February 3 to 6, 1962.

Action: Dr. Allman was authorized to attend the Congress as the Society's official representative with expenses paid.

HEALTH CARE OF THE AGED

Received and noted was the following report on the meeting of the National Joint Council to Improve the Health Care of Aged attended on December 15 by Dr. Hahn and Dr. Eckstein as the Society's representatives.

The meeting in Chicago was under the auspices of the Joint Council, which includes the American Dental Association, the American Hospital Association, the American Medical Association, and the American Nursing Homes Association. The purpose of the meeting was to bring a review of selected medical research on the problems of the aging. It was to present the successful voluntary programs in improving health care, and to encourage continued participation and cooperation of all community health agencies in meeting the demands and needs of this growing segment of our society.

The entire meeting indicated that the program of The Medical Society of New Jersey for the chronically ill and the aging is well oriented but that *implementation of the ideas is urgently needed.* This can best be done through cooperation of the county societies. Education of the public, the patients, the physician is an essential step.

COLLEGE OF AMERICAN PATHOLOGISTS

Received was an announcement of a National Blood Serum Cholesterol Survey conducted by the College of American Pathologists, aimed at improving the methods and accuracy of cholesterol measurements. Those wishing to participate will obtain an application from the Standards Committee, College of American Pathologists, Prudential Plaza, Chicago 1, Illinois.

TRAINING COURSE IN DIET THERAPY

Request was received for permission to list our Society as a co-sponsor of a training program in diet therapy. This is part of a "Workshop Series," offered by Rutgers, The State University, in cooperation with the New Jersey Department of Health.

Action: It was agreed that our Society will co-sponsor the Refresher Training Course in Diet Therapy.

REPACKING OF SAMPLES

In a letter from the State Commissioner of Health, attention was directed to a memorandum sent on September 13 to physicians, pharmacists, and pharmaceutical manufacturers by the Commissioner concerning the carelessness and abuses in handling of physicians' samples. Dr. Kandle concurred with the following recommendations of the U. S. Commissioner of Food and Drugs:

1. A reduction in the distribution of samples to that quantity which may reasonably be used by physicians in their practice.
2. A system of accounting for drug samples to avoid accumulations and diversion for sale.
3. Encouraging physicians to destroy samples which they do not use in practice.
4. A practice of *not* using physicians' samples to fill prescriptions, and use of only those drugs, the integrity of which is beyond question in pharmacy practice.

The Commissioner stated that the Department of Health has been carrying on an active investigation in this field. The practice is sufficiently widespread, "and in our opinion irresponsibly unethical, that we bring it again to your attention for possible action and to seek your advice to us."

This matter had been before the Judicial Council in December 1960; Council then said: "that the selling of these samples by physicians to any person or agency is both unethical and unprofessional . . ."

Action: The membership will be circularized on the subject through the *News Letter* stating that the Board of Trustees agrees in principle with the recommendations of the Commissioner; and that the Commissioner will be notified that the Judicial Council has previously taken a stand on this same matter.

MEDICAL-OSTEOPATHIC LIAISON

At the meeting of the liaison committee on January 18, matters of a general nature were discussed. No recommendations were arrived at for official consideration. The committee is valuable as a clearinghouse for discussions that will be productive of understanding and cooperation. This report was accepted.

AUDIT REPORT

The Board considered a communication from J. S. Teunon & Company, Certified Public Accountants, detailing the reasons for the increase in fee for the audit of the Treasurer's books for the fiscal year ending May 31, 1961. The bill totaling $1,107 was $182 above the budget appropriation. This bill has not yet been paid. It was reported that the Chairman of the Committee on Finance and Budget, Dr. Allman, had approved the bill for payment but that payment had been withheld by the Treasurer who questioned the increased bill.

Action: The auditor's bill will be paid in full as submitted.

DISTRIBUTION OF BOARD MINUTES

The Board of Trustees on February 21, 1960, directed:

That all previous actions concerning the distribution of the minutes of the meetings of the Board be amended to reflect that the Board minutes will not be submitted to anyone excepting Trustees until the minutes have been verified at the next meeting of the Board.

Currently, Board minutes are distributed to the Trustees following the meeting; and, upon verification of the minutes of the next meeting of the Board, copies are distributed to the AMA Delegates, the Judicial Councilors, MSA, MSP, and secretaries and executive secretaries of component societies.

Mr. Nevin pointed out that, in accordance with the above practice, there is considerable delay—one to two months—in letting these groups know, particularly the component societies, about the items considered and acted upon by the Board. He suggested that the minutes of Board meetings be distributed to all following each meeting with the following notation stamped in red at the top of the first page:

FOR YOUR INFORMATION. These minutes will not become official until they are formally acted upon at the next Board meeting.

Action: The suggestion of the Executive Officer was approved.

QUESTIONNAIRE ON CAPITAL PUNISHMENT

A questionnaire on capital punishment was received. It was sent to correspondents of the United Nations on social defense and to nongovernmental organizations—concerning the deterrent effect of capital punishment and effectiveness of the abolition of capital punishment. Our copy was received by the Executive Officer with a request that he obtain the reaction of the Trustees to the questions.

Action: The Executive Officer was instructed to reply that The Medical Society of New Jersey, as such, has taken no position and as an organization cannot take any position on this type of subject.

LETTERS TO GOVERNORS

Mr. Nevin suggested that it would be diplomatic and courteous if letters from the Board, over the signature of the President, were sent

to Governor Meyner thanking him for courtesies during his terms as Governor, and to Governor Hughes offering the cooperation of The Medical Society of New Jersey in whatever way it can be helpful.

Action: The suggested letters will be sent.

RETIREMENT PLAN FOR PHYSICIANS

The Special Committee on Retirement Plan for Physicians met on January 7, 1962. The committee had available the following documents:

1. Report from Mr. Backes concerning medical corporations or associations: Thirteen states have legislation which would allow physicians to incorporate or to form associations taxable as corporations. "The danger of moving such legislation and making expenditures for associating or incorporating in conformity with the requirements of the new law lurks in what might be done in Washington, D. C. to change or nullify the trend. It is reasonable to assume because the Treasury regulations were written apparently to deny this tax break to professional people, and since one of the chief objections to the Keogh legislation has been the tremendous loss in tax income anticipated that the Treasury Department will not sit still when the same loss can be anticipated from State legislative maneuvering."

2. *Medical Economics*, issue of January 1, 1962: In five states (Florida, Ohio, Oklahoma, Pennsylvania, and Wisconsin) corporations or associations with a single member are already permitted. Count on at least a few solo physicians there to try it for the tax break. There are ten states that require more than a single incorporator (Alabama, Arkansas, Connecticut, Georgia, Texas, Illinois, Minnesota, Nebraska, South Dakota, Tennessee). There solo doctors may still try for tax relief on retirement savings. As the AMA's Hirsch explains it: Three doctors, all in solo practice, could set up three separate corporations—one for each man's practice. Each doctor would serve as an incorporator of all three corporations; yet he'd work for, own stock in, and be paid only by his own. Right now the idea is still untested—but it's bound to be tested soon.

3. Report from Mr. Backes concerning New Jersey legislation: Senators Stout, Ridolfi, and others have indicated interest in a professional corporation bill. Such a bill is currently being drafted by the State Law Revision Department which intends to take the best of the existing sixteen statutes. The department is aware of our interest. During the drafting stage and later, will confer with us. Sometime ago the Supreme Court of New Jersey was asked for a declaratory judgment and refused to act, indicating that the legislation would first have to be enacted and subsequently tested.

In New Jersey, statutes require at least three persons for the formation of a corporation or association. Mr. Backes stated that although the legality of the Florida law has been upheld by its own Supreme Court, the impact of its economic effect is now being considered by the Internal Revenue Service. The American Bar Association has studied the question and said that it appears to be ethical as it applies to attorneys. Mr. Backes warned that, with a change in legislation to permit medical corporations or associations in New Jersey, there would be considerable expense to physicians forming corporations or associations to comply with the law; and after going through all the trouble and expense the Internal Revenue Service could change its regulations to prevent the further loss of tax dollars; and all the work done and expenses incurred would go down the drain.

Mr. Backes also stated that in view of what is being done by those representing other than medical interests, let them go ahead with law revision and carry the ball—just make sure that the bill includes physicians. If it works, that it fine; and if not, the Medical Society and its members have not lost much.

Mr. Steadman, agreeing fully with the comments of legal counsel, stated that the solutions lies in economics and not in legislation. The United States is a full partner in the physicians' income and expenses. The Internal Revenue Service will not let any program slide by which will result in a loss of tax dollars. An educational program on economic leverage is needed. The basic failure in the professions is for the average person to pay his bills out of assets rather than out of his income. Most professional people live beyond their means.

The committee acknowledged Mr. Steadman's opinion that an economic educational program could solve the problem, but indicated such a program would be an impossibility for any organization to undertake. The committee agreed that it should withhold action at this time, review the New Jersey proposed legislation when it is available to make sure that physicians are included, and determine whether such legislation should be supported. The New Jersey State Dental Society has not taken any position. However, there seems to be considerable interest and some informal discussion. Would appreciate being informed of the results of the investigation as well as any position the Medical Society may take.

The committee requested that inquiry be made of the Bar Association Committee on

Federal Taxation as to what their thinking is along this line.

Mr. Backes reported that a copy of proposed New Jersey legislation to authorize professional service corporations is in the mail to the Society now for comment. Apparently the bill will follow the Florida law, which had already been approved as to its constitutionality and validity by the Florida Supreme Court. However, Mr. Backes stressed, this does not mean that it will be acceptable to the Internal Revenue Service in that it may or may not conform to the Kintner regulations which Internal Revenue Service has set up. All it means is that if the bill passes, a physician or a group may incorporate; it does not necessarily mean that they will be allowed tax benefits.

AMA CLINICAL SESSION

The Board approved the following report submitted by Dr. Costello:

The last *News Letter* contained an excellent review of the main activities of the House of Delegates and this report will emphasize a few of them. Perhaps the items provoking the most discussion were in reference to ACS activities—Joint Commission on Accreditation—formation of AMPAC—establishment of Specialty Boards—and reaffirmation of AMA position of pre-payment insurance plans.

The discussion of the pronouncements of representatives of the ACS was long and heated, leaving no doubt as to the feeling of the members present. A great number were members of the College. Since the Trustees had already scheduled a meeting with a committee from the College the Reference Committee commented "while deprecating the action of representatives of the College the Committee felt is should not fan the flames of controversy but agreed with the indignation manifested by the resolutions. They recommended that five of the resolutions—among which was that introduced by our delegation—be brought to the attention of the Board of Trustees for its use at the meeting already arranged for January of 1962 with the College representatives and directing the Board to report as soon as possible."

Resolution 33 introduced by Minnesota asked that "The AMA assume entire responsibility of the endeavors of the Joint Commission on Accreditation." After considerable argument during which it was claimed that the Stover report had covered the problem, the Reference Committee asked that the resolution be *not* adopted but that a Special Committee of the House be appointed to investigate all facets of the problem and report at the 1962 interim meeting.

In 1961, the Board of Trustees approved AMPAC by-laws, which describe it as "a non-profit-voluntary-non-incorporated political action Committee." AMPAC membership is available to all physicians—their wives and members of their immediate families. Emphasis is placed on the non-partisan aspect of the organization. Expense is borne by voluntary subscription.

All participants in the discussion before the Reference Committee were in favor of its formation and objectives emphasizing that it is separate and distinct from the AMA as required by law. The need for this program was stressed.

Organization of committees at State level is exhorted and membership of the profession is urged.

Establishment of Specialty Boards. A resolution on this was introduced by the Oregon delegation and evoked considerable controversy. Discussion led to the belief that the whole question of Specialty Boards should be reviewed. The matter was referred to a Board Committee of which Dr. James Appel is chairman together with a similar Committee of the Council on Medical Education and Hospitals.

Prepayment Health Insurance. A resolution on this topic produced heated discussion. General feeling was that this problem had been very slowly activated. Discussants complained of the slow progress of the Commission formed to study this insurance program and the Reference Committee urged that a high priority be assigned to the Commission so that its objectives may be achieved.

Dr. Costello concluded by saying that all arrangements had been perfected well in advance by the Executive Office, and that these arrangements were most satisfactory and were appreciated by our Delegates.

Action: This report was approved as offered and received with thanks.

CREDENTIALS COMMITTEE

A member of the Hudson County Medical Society elected in October 1961 paid his 1961 prorated county dues but refuses to pay the 1961 prorated State assessment. He intends paying his full 1962 State assessment in January. Is he eligible for insurance? It is the opinion of the Committee on Medical Defense and Insurance that assumption of membership begins officially with the payment of the county and State assessments; and that the 90-day period of grace begins when the Executive Offices receive notification of the physician's assumption of membership, accompanied by the required State assessment. Members of the Committee on Credentials were divided in their reaction to the view of the Committee on Medical Defense and Insurance. The majority felt that the opinion of the Committee on Medical Defense and Insurance was correct. The next

question is: what action may be taken against the above physician if he continues to refuse to pay his 1961 State assessment?

Dr. Mulligan read the following excerpt from the *Bylaws,* Chapter X, Section 1, paragraph b:

> Per capita assessments shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a new member admitted after September first of any calendar year, only one-half (½) of the regular per capita assessment shall be levied.

Dr. Greifinger reiterated that election to membership in a component society *automatically* makes a physician a member of The Medical Society of New Jersey. Thus, it is unconstitutional for a physician to be accepted as a member at county level without payment of the State Society assessment.

Action: The Hudson County Medical Society will be informed that unless a physician pays the appropriate State assessment *immediately* following his election he is not a member of The Medical Society of New Jersey and therefore cannot be a member of the component society.

BLUE SHIELD ELDER CARE

Mr. Nevin read a statement adopted January 12, 1962 by the AMA Trustees:

> In December 1958 a policy adopted by the AMA House of Delegates recommended that physicians "expedite the development of an effective voluntary health insurance or prepayment program for the group over 65 with modest resources or low family income," and "that physicians agree to accept a level of compensation for medical services rendered to this group, which will permit the development of such insurance and prepayment plans at a reduced premium rate."
>
> The Board of Trustees believes that a plan proposed by Blue Shield for national coverage of physicians' services for those over 65 under certain income limits conforms with the spirit of this policy. The Board of Trustees recommends that the constituent medical associations take such action as is necessary to cooperate with the proposed Blue Shield plan, and applauds this effort by the Blue Shield. Details of the Blue Shield program will be released to the press in a joint statement by the AMA and Blue Shield Thursday afternoon, January 18. It is urged, therefore, that nothing be mentioned to your local press until that time.

Details of the plan were not supplied by the AMA and the only specific information was that in the newspapers. Contact was made with Dr. Alfano who did not receive detailed information from National Blue Shield until the afternoon of January 18. Feeling that there were certain to be difficulties from the insurance point of view, it was suggested to the chairman and the President that Dr. Alfano be invited to the Board meeting to discuss the proposal.

Both Mr. Nevin and Dr. Alfano stressed that newspaper reporters are calling and wanting to know when the program will go into effect in New Jersey. It has been explained that certain matters need consideration before the plan could be put into effect; several items will require approval, not only by the Plan Board and the Medical Society, but by the Department of Banking and Insurance. Dr. Alfano outlined the proposal from information supplied by National Blue Shield Plans. It contemplates a nationwide uniform contract for persons over 65 years of age which will include the following:

> Basic surgical-medical benefits—when provided and billed for by a physician:
>
> a. Surgery—wherever performed.
> b. Anesthesia service—when rendered by a physician other than the surgeon or his assistant.
> c. In-hospital medical care—physician's visits to hospitalized patients up to XX days each admission (not less than 30 nor more than 70).
> d. Medical care in nursing homes—physician's visits to subscribers confined in a licensed nursing home, limited to XX visits per week (number of visits finally determined will depend on total number of in-hospital visits).
> e. Radiation therapy—treatment for malignancies, wherever rendered, by the use of x-ray, radium, and radioisotopes.
> f. X-ray examinations (with film) for hospitalized bed patients. For outpatients if rendered within 72 hours after accidental injury.
> g. Laboratory and pathological examinations—for hospitalized patients.
> h. Consultation service—for hospitalized bed patients when requested by attending physician. Limited to one consultation per admission.
>
> *Fee Schedule*—While benefits of the program will be uniform in scope, local fee schedules compatible with the following income limits will apply (conversion factors based on the Blue Shield professional services index will be established locally).
>
> *Income Limits*—Covered services will be "paid in full" for single persons whose annual income is $2,500 or less and for a husband and wife with a combined income under $4,000.
>
> *Cost*—Rates will be uniform nationwide to be accomplished by determining a composite of all local plan rates—estimated at $3.10 per month ($9.30 per quarter) for a single person; and $5.90 per

month ($17.70 per quarter) for husband and wife.

Pooling of Risk—The total risk will be shared by all plans in a common pool; thus, popular retirement areas such as Florida and California will be protected against an excessive risk.

Limitations and exclusions will be minimal and will include only such standard exclusions as care furnished under Government or Workmen's Compensation Laws, or the Veterans Administration; cosmetic operations; physical examinations. Preexisting conditions will be covered after a reasonable waiting period, probably 6 months.

Dr. Alfano also outlined some of the problems facing Medical-Surgical Plan of New Jersey if it is to participate in this national program.

The comment of the Secretary of Health, Welfare and Education, Mr. Ribicoff, was that the plan is only a gesture and "what about payment for hospital services?" In December the American Hospital Association and the National Blue Cross Association called specifically for a national program. They proposed 70 days hospitalization, 90 days nursing home care, no consideration as to preexisting conditions, at a rate of $11.80 a month per person. Realizing that this is not for the medically indigent, they suggested that the Federal Government subsidize hospital care of the aged through social security, payroll withholding taxes, or other taxation.

Action: The Medical-Surgical Plan Board of Trustees are requested to include this subject as an item for discussion on the agenda of the joint meeting January 30, 1962.

MSP OUT-PATIENT SERVICE

An expression from the Board of Trustees was requested by the Plan on the following recommendation of the Plan's Internist Committee:

> That the benefits provided by Rider A be liberalized by the Medical-Surgical Plan Board of Trustees, to provide up to $10 for a physician's service in the out-patient department of a hospital when rendered in connection with the initial visit for a medical emergency, and only when rendered by a privately practicing physician who is not under contract with or employed by the hospital.

The reason for liberalizing the benefits under Rider A, rather than under the basic contract, is that the comparable HSP benefit is available only to the automotive industry and, within a short period of time, Rider A will remain in force only for the automotive industry.

Action: The recommendation is approved.

MEDICINES AND DRIVING

Received and noted was a reply from the AMA Committee on Medical Aspects of Automotive Safety concerning the comments of the Special Committee on Traffic Safety regarding the article "A Doctor Warns of Medicines That Menace Your Driving" published over the name of the AMA committee in *This Week* magazine August 6, 1961. A copy of this reply was supplied to the chairman of the Special Committee on Traffic Safety.

NEW YORK HOSPITAL SERVICE

As in past years an invitation was received from the Service for the Society to recommend the names of two members for directors in the organization. It was noted that for more than ten years we had submitted the names of candidates. None had ever been selected.

Action: The communication will be received and noted on the same basis as last year.

HISTORY OF MEDICAL SOCIETY

At the November meeting it was agreed that funds from the annual meeting reserve account would be made available to the Society's Historian-Archivist, Dr. Rogers, to bring the history of the Society up to date. Dr. Rogers now asks whether it was the intent to publish the Medical Society's 200-year history in 1966. Publication would be the major expense. Dr. Rogers expressed the opinion that before undertaking any extensive research, which he is willing to do, he would like assurance that the results of his efforts will be published.

The Board was unanimously in agreement that the 200-year history of The Medical Society of New Jersey would be published in 1966. Whether the publication would be distributed as a benefit of membership or sold at cost price would be a matter for later determination.

The Board requested Dr. Kaufman to assure Dr. Rogers that his efforts in behalf of the Society are appreciated, and that the history will be published.

JANUARY 30, 1962

On January 30, 1962, our Board of Trustees met jointly with the Trustees of Medical-Surgical Plan. This session was called at the request of the Medical Society Board of Trustees to discuss the proposed revision of the MSP Bylaws, and to discuss the Blue Shield National Program for the Aged. The following MSP Bylaw revisions were proposed:

1. To create the office of Chairman of the Board of Trustees;
2. To make the President a full-time salaried officer, who may also be the Medical Director; and
3. Retain the Executive Vice-President as a full-time salaried officer who may also be the Medical Director.

Dr. Schaff outlined the reason for the suggested revisions:

Aim of the proposed changes in the Bylaws of Medical-Surgical Plan is to establish efficient means of operation. The changes would not only strengthen the present organization but would also alleviate the necessity of phone calls and correspondence by the Executive Vice-President on matters pertaining to the corporation, for he has no power to make decisions. Therefore, to have better organization, it is proposed that Medical-Surgical Plan have (1) a Chairman of the Board; and (2) a President who would be a full-time salaried officer. Such an arrangement would provide better liaison not only with the Blue Shield Plans but also with Hospital Service Plan of New Jersey which has a similar table of organization. In addition, the tremendous growth of the Plan to its current size has greatly increased the administrative details of the executive offices, and therefore necessitates a President who is available full time and can work on an equal basis with the comparable officer of the Hospital Service Plan.

The Medical Society Board presented the following amendments to the proposed revisions:

Article IX, second paragraph, third sentence:

"The President and any other officers elected need not be members of the Board of Trustees."

Amend to read:

"The President *shall be a Doctor of Medicine, a member of The Medical Society of New Jersey, and a member of the Board of Trustees of the Plan.* Any other officers elected need not be members of the Board of Trustees."

Following discussion it was agreed by the combined Boards, without a dissenting voice, that the amendment would read:

"The President *shall be a Doctor of Medicine, and a member of The Medical Society of New Jersey.*"

It was unanimously agreed that "The President and any other officers elected need not be members of the Board of Trustees," and that it would be left to the discretion of the Plan Board as to whether the Plan President would be a Board member. Mr. Minard pointed out that as President of HSP, he "may" be a member of that Plan's Board, but he has not been so elected.

Article X, Section 2, paragraph b., add the following as the fourth sentence:

"He (meaning the President) shall be an ex-officio member of all committees."

The above amendment was unanimously accepted.

BLUE SHIELD PROGRAM FOR THE AGED

Dr. Schaaf stated that at the Plan Board's regular meeting on January 23, 1962, the Board gave its "approval in principle" to the national program. The Board's action released to the newspapers further stated: "However, its practical realization is contingent upon the adaptation of the plan to existing conditions and circumstances in the several states. To this end it will be necessary, through conferences with The Medical Society of New Jersey and the Department of Banking and Insurance, to arrive at a practical means of establishing this plan in New Jersey. The Board has directed its staff to survey all aspects of the proposal and to investigate the areas of professional and legislative consideration that must be dealt with."

COMMITTEE ON MEDICAL EDUCATION

To comply with the provisions of the By-laws concerning proposed amendments, the Trustees considered the following proposed revision offered by the Committee on Medical Education which had met on January 21, 1962:

The committee proposes that the problems of graduate medical education and of intern and resident training should be of some continuing interest to the Medical Society, and that this committee would appear to be the logical group for such activity. It therefore *recommends* that the following additions be made to Chapter IX, Section 14—Committee on Medical Education:

(c) This committee should maintain an active interest in and make recommendations to The Medical Society of New Jersey with regard to the continuing medical education of its members.

(d) This committee shall also maintain a continuing interest in the intern and resident training program in the State.

The Trustees present approved the above proposed amendments for transmittal to the Committee on Revision of Constitution and Bylaws.

Dr. Mulligan directed, with the concurrence of the Trustees, that the report of the Committee on Medical Education be included on the agenda of the next regular meeting, so that the above referral can be affirmed by the full Board, and so that the balance of the committee's report can be considered.

The Journal Loses Mrs. Armstrong

This is the first Journal issue in 21 years to appear without Mrs. Armstrong's guidance. She left the Society's service last month. Mrs. Armstrong first came to us on January 2, 1940, as secretary to the late Dr. Norman Scott, who was then developing the Medical-Surgical Plan. Miriam Nilis, as she then was, was graduated from the Bristol (Penna.) High School as an honor student at the age of 16, and then crossed the Delaware to do secretarial work for the John A. Roebling Company, the well-known Trenton bridge builders and engineers. At Roebling's she soon became private secretary to one of the executives, and was then persuaded to come to The Medical Society of New Jersey.

Several months after Miss Nilis became a Medical Society employee, she was assigned to the editorial office. A year later she became Mrs. William Armstrong. But she didn't stop being editorial secretary. When I became editor in the spring of 1941, Mrs. Armstrong had already mastered the mysteries of proofreading, dummy-making, type-sizing, and magazine make-up (not to mention typing, billing, shorthand, and bookkeeping). She was certainly indispensable to me, as she would have been to any new editor. She could flawlessly transcribe even my staccato dictation and her knowledge of both Society organization and journal make-up constituted a road map through what would otherwise have been a bewildering world.

Mrs. Armstrong for more than 20 years was this Journal's prime technician. She handled illustrations, circulation, proofreading, bills, correspondence, advertising, and subscriptions. Singlehanded she laid out each month's advertising dummy. Her sharp and well-educated eyes detected errors in spelling and punctuation. The Board soon discovered that her contribution to Journal operations was well above the simple secretarial level—though that was important enough. In 1947 she was promoted to assistant editor in recognition of this increasingly valuable service.

This Journal has always been important to Mrs. Armstrong. She has a fierce loyalty to the Society in general and to the Journal in particular. The adjective "dedicated" is somewhat shopworn with overuse, but in this instance it is exactly the right word. She truly dedicated herself to the preparation and perfection of our periodical. In medical journalism, The Journal of The Medical Society of New Jersey has enjoyed very real status. This has been achieved with a tiny staff: the editor, the assistant editor and a part-time advertising solicitor. It has been a thrifty, efficient and productive operation. More than to any other factor, this has been due to the labors of Miriam Armstrong.

It would not be fitting to allow her to slip quietly out of the editorial office without this brief appreciation of a difficult and often thankless job done exceedingly well.

Henry A. Davidson, M.D.
Editor

Letters to The Journal • • •

Relative Value Index

In response to the article published in THE JOURNAL, February 1962, page 100, two communications were received—both from members of the Camden County Medical Society.

The first letter reads as follows:

Thank you for answering this skeptic's queries so that he may approach the gratification, grace, and glibness of the "informed."

1. You use the sandwich-and-coffee example so simply, but confuse us when Nebraska's RVI happened "to be in my pocket." Their routine follow-up office visit is set at 2.5 units. It was my belief that California and New Jersey, *et al.*, considered this as the simplest base. Help me figure why under the sun you took Nebraska as your explanatory state example?

2. It was reassuring to hear that 16 states are pleased with their scales. However, would you clarify why New Jersey needs an index at this time? Are physicians having difficulty with Blue Shield, with Workmen's Compensation, with private insurance, with aged and welfare care, or other? And if with any of these third parties, is it the brand of difficulty that will be settled by an RVI?

3. What does Texas think of RVI?

4. Emphasis is placed on the doctor's inalienable right to supply his own conversion factor. Since we are justly concerned when dealing with third party hanky-panky, does it disturb you any that the third party may not look favorably upon Dr. A's 20 per cent higher—than—Dr. B's conversion factor? Do you genuinely believe that they (third parties) will recognize each conversion factor of the multitude—or even of two already?

5. Finally, please give us your concise refutation of the truism that RVI tends to standardize doctors, treatment, and patients.

When these simple queries are answered and explained, physicians will approach the impending mail poll in a more informed state.

Thank you for your continued equitable and patient handling of this damnable problem.

In answer to this letter, Dr. Klompus writes:

1. Nebraska's RVI happened to be at hand when I was composing the piece. The fact that indices do vary is a point in their favor since each state is free to do as it sees fit. I am all for differences; for local approaches to local problems.

2. The answer to this question is obvious to anyone who looks at his mail. *Item one*: Blue Shield is having trouble with the legislators who want to dictate fees. Blue Shield is a dollar schedule; it is not entirely the medical profession's latest idea; it may have to be turned into an indemnity plan if the take-over succeeds. RVI is not in dollars; it can therefore be revised more quickly and is immune to take-over; it is not binding on anyone; no one will be asked to sign an agreement to accept any payment under any circumstances. *Item two*: The state welfare people are now trying to organize a vendor payment arrangement. RVI would be of help in their attempt to allocate present medical monies. If the New Jersey legislature ever passes the implementing machinery and matching funds, there will be large amounts available for the aged indigent under the AMA-approved Kerr-Mills bill. These people are now being treated on our hospital wards free. Hospitals are paid through appropriations from local governmental agencies, but doctors are not. This picture may change.

Item three: Righ now the Blue Shield's schedule of dollar payments is being used arbitrarily to set fees for workmen injured while working for the State of New Jersey. Adoption of RVI would permit the negotiation of fair fees according to the wishes of the doctors themselves who have set up, and agreed to, the fair relationships in their RVI.

3. As to Texas, I bow to no man in my admiration of this huge state with its great diversity of industry, agriculture and mining. Apparently they have no desire to adopt the RVI. This is their prerogative and indicates how wise the AMA has been in suggesting that RVI be adopted according to the wishes of

the several states. Sixteen states have adopted an RVI. None have rescinded the plan. Several others are expected to follow suit in the near future.

4. The conversion factor should be considered on two levels. In dealing with large consumers of medical services (such as New Jersey State Department of Welfare, Blue Shield, unions, and the like) a doctor could abide by this factor or not as he pleased, as long as he has signed no agreement to accept a conversion factor that the group has set, even with the agreement of the Medical Society. *Second,* in his private practice, the conversion factor is his own business, and he will not have to declare it, register it, or reveal it. The medical market place always sets the conversion factor for an individual doctor. In addition, a disclaimer that RVI is binding in any way or that it can be considered as anything but a fair guide can be incorporated on each page of the finally adopted RVI.

5. There is no "truism" that RVI standardizes patients, doctors, or treatment; nor is any attempt being made to do so. The RVI is solely a guide for the fair evaluation of medical services in relation to each other. Patients are infinitely variable beings; so are doctors. As to medical services, you know as well as I that no two doctors do an appendectomy exactly in the same way. No place in any RVI that I have examined is there any mention of standardization of services. To catalog services is not to standardize them.

Finally, this is not a "damnable problem." Eleven of the twelve members of the Council on Medical Services have studied RVI for five years. We are certain that it is an approach to one segment of medical economics which needs sane, careful thought and a definite position by the New Jersey Medical profession.

The second letter reads:

I am interested in the council's projected RVI. Please elucidate the following problems on my mind.

1. Advocates of RVI point out that this is not a fee schedule. California is the *avant-garde* of such studies. Why is their guiding group known as the "Committee on Fees?"

2. Would you be so kind as to enlarge on the risk of possible stereotyping of physician approach to patients with an RVI application?

3. Is it not true that 75 per cent of cost and effort in an RVI manual (and its inevitable revisions) is devoted to the procedures of surgeons who represent less than 35 per cent of the medical population?

Congratulations on your fine February article. I will be eagerly awaiting your informal answers.

In answer to this second letter:

1. It is true that in California the Committee on Fees, which is a subcommittee of their Commission on Medical Services, has been responsible for their Relative Value Study. Our entire Council on Medical Services has been engaged in this study, rather than just a small subcommittee. The RVI is certainly concerned with fees. It has to do with judging the adequacy of existing fee schedules; it derives from a study of doctors' present fees; it is certainly a yardstick of fees. However, it is not a fee *schedule* with any of the rigidity implicit in such a device. It is not binding on any doctor. "Compliance is optional with the physician," to quote the heading of every page of California's third and latest Relative Value Study. The attention of the committee was directed to RVI as the result of a request from the Trustees to study dollar fee schedules proposed by unions and a large utility company and complaints from a surgical specialty group. We found this such a complex matter that we were forced to the realization that only the concept of a RVI would give us a decent gauge and set of criteria for handling these problems.

2. Your second question is answered above, I believe. However, let me point out that RVI has no application forms; it doesn't dictate procedures and methods; it is simply a catalog of most medical procedures followed by a valuation in units which is related only to other medical procedures. These values are set by the doctors who perform them and are most familiar with the medical procedure involved.

3. I have not counted up the various procedures and the categories of physicians involved. If what you say is true—and I do not doubt you—let us then insure that every member of our profession is represented by as many or as few lines as he tells us is required properly to catalog the procedures of the specialty involved. We will revise and change as often as it seems indicated by the opinion of the doctors concerned and as directed by them.

FOLLOW-UP NOTE

The 1961 House of Delegates returned the proposed Relative Value Index for further study for another year by all parties concerned. Following publication of this second article, a mail poll of the membership, to determine the overall reaction to the proposed Relative Value Index for New Jersey, will be taken so that a full report can be presented to the 1962 House of Delegates for final action.

Untoward Effects of Triparanol

Sir:

On page 29 of the February issue of THE JOURNAL is an article by Dr. Marvin C. Becker entitled "Clinical Experience with Triparanol." In his summary Dr. Becker states: "2. The drug is a simple, effective, non-toxic means of lowering serum cholesterol . . ."

I wonder whether that declaration is acceptable in view of the communication dated December 1, 1961, from the William S. Merrell Company, signed by Carl A. Bunde, Ph.D., M.D., Director of Medical Research, captioned "DRUG WARNING—Mer/29 (Triparanol)," sent to me and presumably to other doctors. I assume that you also received this communication but, if not and you wish to peruse it, I can send you my copy.

This warning, sent in cooperation with the U. S. Food and Drug Administration, invites attention to the occurrence of various adverse effects from the administration of Mer/29, amongst which are mentioned cataracts, hair changes, icthyosis and other skin changes, depression of adrenocortical function, etc., and states this caution: "In view of all reports concerning adverse effects, it is recommended that Mer/29 be used only in patients who can be maintained under very close observation and supervision. Dosage should never exceed 250 Mg., per day."

In view of this warning letter from the manufacturer, and the adverse effects it reports, and the caution it stresses, I wonder whether item 2 in Dr. Becker's summary is justified? My inference is that this article must have been composed before the sending of the warning letter, or that said letter was not seen by Dr. Becker. And I am quite sure that you had not read that warning letter, else you would have required that Dr. Becker suitably modify paragraph 2 of his summary, or add a stipulation as to the danger of side-effects and as to their possible nature.

ALBERT G. HULETT, M.D.

Sir:

My preliminary report on Triparanol was first read at a meeting of the N. J. Chapter of the American Federation of Clinical Research on December 7, 1960 and consisted of studies varying from 3 to 9 months on a series of 23 patients. The paper was then slightly revised and sent to THE JOURNAL of The Medical Society of New Jersey and a letter of acceptance was received on May 17, 1961. On June 14, 1961 a galley proof was forwarded to me. So it can be seen that my paper was read a year before the *Drug Warning* communication of December 1, 1961 which Dr. Hulett refers to. The paper was accepted for publication 7 months before and a galley proof sent 6 months before that communication. Publication of the paper occurred 2 months after that. Dr. Hulett's inference is certainly correct—namely, "that this article must have been composed before the sending of the warning letter." In fact, long before.

In my paper I did report dermatologic complications in one patient and impotence in another. I did not see any liver damage or renal or hematopoetic toxicity as yet. I later had another patient with itching and one who had a transient alopecia which was corrected when the drug was discontinued. I have seen no cataracts.

Since this communication of December 1, 1961 which I did read and which by the way—my patients read only too well, I have for the most part discontinued the use of the drug except in those patients who insist it helps their angina and will accept the risks after a complete examination.

All this points out that the long delay that takes place in the publication of papers occasionally places the author in a peculiar light in view of subsequent developments and may also cast doubt as to the quality of his observations. What originally was an early preliminary report on an interesting new drug becomes old hat and obsolete before publication. Furthermore, late publication might prevent early recognition for some original work. I realize that the work of an editor is a difficult one and that perhaps there are too many papers which never should have been written but I believe that much trouble could be avoided if in the future there is a slight change of policy. I feel that the date of submission of a paper should be placed in THE JOURNAL accompanying each article. There is nothing new about this. Many medical journals do this.

MARVIN C. BECKER, M.D.

Psychotherapy: Rebuttal Testimony

In the October 1961 JOURNAL, Dr. J. L. Morrow published an article urging physicians to send patients needing psychotherapy to physicians rather than to psychologists. In the March 1962 issue, we published a letter from Stanley Moldawsky, Ph.D., which took issue with Dr. Morrow. Dr. Moldawsky's position was that psychotherapy should be done by the persons best trained to do it, regardless of the possession or lack of a medical degree. Dr. Moldawsky quoted the Joint Commission on Mental Illness and Health which agreed that professional persons lacking a medical education might be able to do psychotherapy well by reason of aptitude, training and competence. Dr. Morrow now replies to Dr. Moldawsky.

Dr. Moldawsky's critique of my article[1] is an excellent theoretical brochure on the training and personality of the psychologist in private practice; however, it fails to come to grips with the question of why I have urged that referral for psychotherapy should be only to the psychiatrist. Dr. Moldawsky feels that these patients should be referred to clinical psychologists because they (or their certified group) have qualifications in psychotherapy which, he infers, many psychiatrists lack. He attributes my own position to oversimplification, to mistrust, to "mislabeling of malfunctioning psychologic processes as illness," and to interprofessional competitiveness.

My thesis (and that of the American Psychiatric Association, the American Psychoanalytic Association, and the American Medical Association) is that *the care of the sick is the responsibility of the medical profession*, and that the care of the mentally sick is the primary responsibility of psychiatry. Medical practice is a unitary whole. It involves a comprehensive approach to the patient. It is not a practice based on psychotherapy alone. Psychotherapy is only one form of psychiatric treatment and at any point in the treatment of an illness, psychologic symptoms may give rise to, substitute for, or run concurrently with physical symptoms, or *vice versa*. Therefore, psychiatry (and all medicine) must oppose the independent isolated treatment of psychologic symptoms by nonphysicians except in settings where adequate psychiatric safeguards exist and where medical responsibility for the diagnosis and treatment of the patient is clearly established and continuously present. Collaborative and cooperative effort with psychologists is a desirable practice. Psychiatry has always felt an obligation to encourage other professions to assist in the care of the mentally ill. This can be accomplished only under an arrangement whereby the physician assumes responsibility for the patient, though he may delegate certain procedures to other professions. Any other arrangement would endanger the safety of the patient.

Dr. Moldawsky's position is that only the psychoanalytically trained and personally analyzed individual has the competence to do psychotherapy. However, his objectives are those traditionally ascribed to the psychoanalytic method and require that the patient have a reasonably strong ego structure and certain intellectual capacities; the patient must be free of incapacitating social interference, and have sufficient means to justify the expense of three to five sessions per week. The top spokesman for this is the American Psychoanalytic Association. Among other qualifications, this Association requires that candidates for training and practice in this field must be graduates of Grade A medical schools. Psychoanalysis is part of the curriculum of acceptable psychiatric residencies; and many residents seek personal analysis at this time or later; it affords insight and knowledge into the basis of human behavior. Psychoanalysis, however, lacks the scientific precision of the other biologic sciences. The various "schools" of psychoanalysis have widely different orientations. In that sense, psychotherapy depends on one's orientation and training. Psychotherapy includes supportive therapy, re-educative therapy, and reconstructive therapy.[2] Different therapists by virtue of their unique personality and specialized training apply themselves to one or another technical procedure with greater or lesser facility, and patients selectively respond to some therapeutic methods and not to others. There is no "best" therapy; that is best which happens to suit the patient's needs at the time he applies for treatment. Depth therapy of the type Dr. Moldawsky describes may precipitate psychotic episodes unless done in a protected hospital environment. Many hitherto considered intractable illnesses have been helped by drugs and physical procedures with little psychotherapy. The vast majority of patients have limited means and are ill-prepared for idealistic depth psychotherapeutic procedures; yet they show remarkable progress which the common sense approach seems to effect. An analyzed psychotherapist offers no greater guarantee of success than the unanalyzed therapist. Just as Osler and Jackson had "It" in medicine so some psychotherapists have "It" in terms of success whereas others do not. Comprehensive training is needed to make a final diagnosis of a nervous or mental disorder based upon access to a wide array of physical, chemical, biologic structures which the psychologist (despite intensive training in psychological testing) cannot do either before, during, or after psychotherapy.

Dr. Moldawsky asks whether mental illness is a sickness at all. If it were not, it would lie outside the physician's domain. Szasz[3], to be sure, does support this cynical position. But Szasz is almost alone here. Huston[4] points out that "sickness is a concept of many meanings and may include persons with or without pain or discomfort, personality maladjustment, school failure, marital disharmony and so on. Whenever a person is considered sick from the standpoint of common usage and understanding of the term and of good medi-

cal practice, then such a person should be examined by and be under the care of a physician. Psychiatrists have consistently held the view that a significant number of persons who may be called maladjusted, emotionally disturbed or who have a behavior or personality disturbance may also be sick and that this sickness is an important contributing factor or is the essential basis of the maladjustment or personality disturbance." In like sense Dr. Davidson's[5] semantic references must be read in his context. In the medical sense, psychotherapy does not include legal advice, social case work, personnel counselling, vocational guidance, or education because these activities by themselves (if divorced from a medical setting) do not have the medical intent of curing or alleviating an illness. They do not involve a medical diagnosis or a decision as to whether a certain form of psychotherapy is to be combined with some type of physical treatment.

Reference has been made to the recommendation of the Joint Commission on Mental Illness and Health[6] suggesting the need for a crash program. Many physicians and many psychiatric organizations and medical societies have questioned those portions of the report suggesting the care of the mentally ill not only by "non-medical mental health workers with aptitude, sound training, practical experience and demonstrable competence to de general, short-term psychotherapy—such therapy combining some elements of psychiatric treatment, of client counselling, of 'someone to tell one's troubles to', and 'of love for one's fellow man'." However, even in the report there is the feeling that all these groups should be fitted into the total professional structure in such a way that the welfare of the patient will be protected. Thus, this report, despite its undesirable features, does bear out my thesis that the care, treatment, and responsibility for the mentally ill patient must remain the function of the psychiatrist.

J. L. MORROW, M.D.

This exchange could go on interminably, and it will exhaust the reader before it exhausts the subject. It strikes your editor (who is not precisely objective in this) that no matter how you put it, the psychologist is, so to speak, one degree behind. At any rate, this letter must terminate the correspondence. Readers who wish the specific citations referred to above may get them from Dr. Morrow at 197 Passaic Avenue, Passaic.

The Medical Political Action Committee

The Board of Trustees, at its meeting on February 18, 1962, voted unanimously to endorse officially the American Medical Political Action Committee and to encourage the members of The Medical Society of New Jersey—voluntarily and on an individual basis—to support AMPAC.

It was the further action of the Board that the above action and the purposes and goals of AMPAC be publicized in the *Membership News Letter* and THE JOURNAL.

The purposes of AMPAC, which is an organization separate and distinct from the American Medical Association as required by federal law, are:

1. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.
2. To encourage physicians and others to understand the nature and actions of their government as to important political issues and as to the records and positions of political parties, officeholders, and candidates for elective office.
3. To assist physicians and others in organizing themselves for more effective political action and for carrying out their civic responsibilities.
4. To do any and all things necessary or desirable for the attainment of the purposes stated above.

Book Reviews

A Polychrome Atlas of the Brain Stem. By W. S. J. Krieg, Ph.D. Chicago 1961. The Anatomy Department of Northwestern University Medical School in Chicago. Pp. 20. ($3.00)

The dream of every neuro-anatomist, neurologist and medical student is a staining method that would dye the fibers of each functional system a different color. This booklet is as close as we will get to that dream. Professor Krieg has taken a dozen sections through the brain stem from the level of the mid-cervical cord, rostrally to that of the superior colliculus. Every functional system (motor, auditory, cerebellar, extrapyramidal and so on) has a consistent color which is maintained in all plates. Each page-complex carries the stained sections showing fibers, a drawing showing cell structure and a textual description. The atlas is a wonderful supplement to actual slides (in fact, they are pedagogically more useful than Weigert sections) and a compact refresher for clinicians. It is a beautiful book that will help anyone understand better the marvelous structure of what is surely the key structure of the whole world: the human brain.

HERBERT BOEHM, M.D.

Childbirth with Hypnosis. By William S. Kroger, M.D., edited by Jules Steinberg. Garden City, N. Y., 1961. Doubleday. Pp. 216, illus. ($3.95)

Designed as a text for the layman, this book fulfills its purpose. It is written in an easy style with a minimum of heavy, unexplained, "medical" terms and does much to answer the obvious and not so obvious questions concerning this popular subject.

The authors present a factual, yet interesting history of pain relief in medicine, for childbirth as well as other conditions. Unfortunately, the temptation was too great, and hypnosis is portrayed as the true "last word" in obstetrical analgesia and anesthesia.

It is interesting that, after making an issue of the incorrect terminology so many of us fall into by calling contractions "labor pain," the authors persist in this error and use this term throughout the remainder of the book. It is a blow to many of us who have devoted years to the crusade of having them called—rightfully—contractions.

Rarely would anyone find areas of argument with Dr. Kroger as he describes the intricacies and technics of hypnosis in the book. There are assertions, however, in the final section, "Discomforts of Pregnancy," which many of us would question. Particularly are the statements referable to the efficacy of this technic in habitual abortion and, of all things, constipation, a little too "pat" to be acceptable.

For those in our profession who use the therapy, this book is a tremendous time-saver as an explanatory text for their patients. For those who do not wish to use hypnosis, this volume might well prepare them for the frequent queries of today's "modern" obstetrical patient.

EUGENE J. SLOWINSKI, M.D.

Your Nursing Services Today and Tomorrow. By Elizabeth Ogg. New York 1961. Public Affairs Pamphlet Number 307. Pp. 28. ($0.25) Priced lower in quantities.

The dramatic changes that have taken place in the role of the nurse are highlighted in this vigorous pamphlet. Miss Ogg reviews progressive patient care, home care programs, mental nursing, team nursing, and many other up-to-the-minute concepts. The role of the community is discussed and the patient's "bill of rights" is detailed and interpreted. This brochure is a major contribution to better public understanding of the professional nurse.

JOHN HUBERMAN, M.D

Stroke: Douglas Ritchie. New York, 1961. Doubleday. Pp. 192. ($3.50)

Douglas Ritchie, a radio commentator, suffered a right hemiplegia at the age of 50. He was left aphasic and expected to rot away quietly in a nursing home. He didn't. In an extraordinary—possibly unique—piece of writing, Mr. Ritchie presents a "diary of an aphasic." This document is at once poignant and practical. He describes his illness, his furious and frustrating initial efforts at recovery. He tells how a hemiplegic can take a bath and lace his shoes. Withal, this is no story of self-pity. As one of the manuscript readers says: Mr. Ritchie may have had a hard time of it; but Mrs. Ritchie deserves the George Cross. (The Ritchies are British.) This is a realistic and hopeful book to give to an intelligent patient who has had a stroke.

ABRAHAM LEFF, M.D.

The Changing Years (Menopause Without Fear). By Madeline Gray. Garden City, New York, 1960. Doubleday. Ed. 2. Pp. 273. Paper. ($0.95)

This is a revision of the well-known, easy reading, paper-bound guide to enjoyment of life after the menopause. The book includes a list of names and addresses of "doctors who have helped me"—an item in questionable taste, and probably embarrassing to the many fine physicians so advertised. Although the style is theatrical in spots, and breezy everywhere, Mrs. Gray does cover the ground well and knows how to hold—and solace—her audience. A list of 85 books and articles makes a valuable bibliography. One will not have to agree with all the author's views, to deem this a handy volume. Physicians will find it particularly useful as a springboard for lectures to lay audiences.

VICTOR HUBERMAN, M.D.

Medical Pharmacology; Principles and Concepts. Andres Goth, M.D. St. Louis 1961, Mosby. Pp. 551. ($11.00)

As a textbook of pharmacology this volume is quite short—almost a condensation when compared to other texts. Well-written and well-organized, it is a handy reference for the student and physician. However, it is not sufficiently encyclopedic for many purposes. While the author freely admits leaving out "the type of factual information which students memorize and promptly forget," this reviewer feels that fewer structural formulae could have been offered and more basic information added without enlarging the book. Several chapters are downright sketchy.

RICHARD H. ROBERTS, M.D.

Handbook of Pediatrics. Henry K. Silver, M.D., C. H. Kempe, M.D. and Henry B. Bruyn, M.D. Los Altos, California, 1961. Lange Medical Publications, 4th Edition. Pp. 575. ($3.50)

The success of the three earlier editions of this concise manual represent the best review the book can have. This is one of the remarkable series of Lange Medical Publications, published in soft binding, revised biennially, and selling at a price so modest that any practitioner can afford to have the latest edition in his medical bag or on his desk. The text covers history taking, examination technics, laboratory procedures, feeding problems, and the entire spectrum of diseases of children. There are quick reference tables of ossification development, blood values, anthropologic measurements and so on. Necessarily the authors have to sacrifice detail and depth in order to achieve the remarkable compactness of the book. For instance, the treatment of tics is given simply as "evaluation of adjustment and relief from pressure." However, for ready reference, concrete suggestions and diagnostic tips in the field of purely medical pediatrics, the book is handy, correct and practical. It has just been translated into Greek and Japanese, and it is easy to see why this *vade mecum* has been selected.

RALPH N. SHAPIRO, M.D.

Symptom Diagnosis. By Wallace M. Yater, M.D. and W. F. Oliver, M.D. New York, 1961. Appleton. Ed. 5. Pp. 1035. ($15.00)

Since 1927 Yater and Oliver have been helping the busy physician by allowing him to reduce the diagnostic possibilities to a small list. The format is practical and practicable. More than 50,000 physicians in the last 30 years have used this book, and this should be accolade enough. It inevitably invites comparison with French's famous *Index of Differential Diagnosis* (now in its 8th edition) which is a large volume, in smaller print, giving many more details. The preference is bound to be personal. Most busy practitioners will find Yater-Oliver easier for swift reference, while French is more suitable for study. One thing is sure: Yater-Oliver will promptly justify its space on any doctor's shelf—or better yet, on his desk.

ULYSSES M. FRANK, M.D.

New and Nonofficial Drugs, 1962. Council on Drugs of the American Medical Association. Philadelphia, 1962. Lippincott. Pp. 900. ($4.00)

New and Nonofficial Drugs is an annual AMA publication which describes drugs generally available in the United States that have not yet been included in the *Pharmacopeia* or in the *National Formulary*. Each drug is described by a compact monograph. The book is arranged by major therapeutic action. Also included are the regulations of the Council on Drugs and a tabular summary of the metric system.

The volume is well indexed for a swift reference and constitutes a necessary guide through the dense jungle of new pharmaceuticals developed annually by the ingenuity of American biochemists and pharmacologists.

The Council on Drugs does not conduct clinical or laboratory tests and therefore the listing of a preparation in this book is not the basis for its inclusion in any roster of approved or accepted pharmaceuticals. However, it is an invaluable volume for the guidance of the medical practitioner.

HENRY A. DAVIDSON, M.D.

Health Education: A Guide for Teachers and a Text for Teacher Education. Edited by B. R. Moss, Ed. D., W. H. Southworth, Dr. P. H. and J. L. Reichart, M.D. Ed. 5. National Education Association, 1201 16th St., N. W., Washington 6, D. C. 1961. Pp. 427. ($5.00)

Although written primarily for teachers, this book will be of interest to school physicians. It is a project of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, and has been completely rewritten in this fifth edition. Primarily, the text is concerned with setting forth principles of health education and elucidating current practices. Emphasis is placed on the psychologic aspect of teaching health matters. Basic methodology is at a minimum. The novice health teacher will not, from this book, learn how to prepare a lesson plan; but the areas of curriculum content and curriculum development are treated very well.

No special treatment was given to the problem of sex education despite the broad coverage given to adolescent health problems.

School physicians may gain insight into the problems teachers face in health education by reading this volume.

SEYMOUR F. KUVIN, M.D.

Essentials of Neurosurgery. By Sean Mullan, M.D. New York, 1961, Springer Publishing Co. Pp. 273. With 87 illustrations and drawings. ($6.75)

This book open with radiologic anatomy which includes embroyologic facts, normal and abnormal findings, neuro-anatomy, ventriculography and pneumoencephalography. The text then considers seizures, trauma, discs, neoplasms, infections, pain, and operative technics as related to neurologic surgery. The physiology of brain swelling is well demonstrated by sketches and photographs. Screening out of patients unfit for the trigeminal neuralgia procedure is a particularly good section.

Dr. Mullan explains the proper nursing care of the comatose patient as to position, feeding and observation. He reviews management of the patient with spinal cord injuries and neoplasms. Dr. Mullan indicates the poor prognosis of the patient with a subarachnoid hemorrhage in coma as compared to one that is not. He emphasizes that the ideal time for corrective surgery in children with hydrocephalus is within the first six months of life.

The text is supported by many pertinent sketches and radiologic reproductions. The author has been thorough and precise, and provides ample references for further reading.

ARTHUR WINTER, M.D.

Management of Obstetrical Difficulties. J. Robert Willson, M.D. St. Louis, 1961. Mosby. Ed. 6. Pp. 687 with 323 illustrations. ($16.50)

This revised edition is a comprehensive up-to-date text of obstetric management, written in a concise but comprehensible style. The material is presented in an interesting, easily readable manner. Controversial theories, concepts, and technics are presented clearly with a gratifying minimum within the text, of references to specific research and statistical data. The discussion of labor and clinical and radiologic pelvimetry are especially complete and clear.

Therapy for the more common problems is specifically outlined by procedure and by medication dosage. Newer concepts such as marginal sinus bleeding and respiratory distress syndrome are well presented. Outstandingly good are the sections on infertility, the chapter on obstetric analgesia and anesthesia, and the discussion of the newborn infant.

This volume more accurately represents a text of overall obstetrical management than a guide to solution of specialized obstetric problems.

The recently published atlas by the same author complements this work; neither replaces the other. It is mentioned in discussion of hemolytic disease of the newborn, that management "begins with anticipation." The same concept might well guide all obstetric endeavor, and the presentation in this book goes a long way toward that goal.

J. B. SKELTON, M.D.

Good-Bye, Doctor Roch. Andre Soubiran. Translated from the French by Helen Sebba. New York, 1961, Doubleday & Co., Inc., Pp. 331. ($4.50)

As a novel, this just passes. It has its heroes and villains, its sex, love and intrigue with a happy ending; but the plot is weak and interest flags. It tends to become melodramatic. The heroes are perhaps a little over-heroic and the villains a little too bad.

The story is written as the diary of a sane man who somehow was committed to an "asylum." How he got there is the mystery and how he is going to get out creates the suspense. The hospital is viewed from the standpoint of a patient. Poor food, filth, clamour, uncertainty and danger all become personal experiences. Consequently, there is a greater appreciation of the efforts made by Dr. Roch to improve conditions.

The love angle is given a psychiatric twist by comparing the process of falling in love with the onset of a psychosis, a crystallization, so to speak: and this is what apparently happens to Dr. Roch and our narrator's wife. However, this is all neatly untangled to everyone's satisfaction and Dr. Roch is left free to battle for his patients.

Mental hospitals are in need of improvement and the public should be made aware of the existing conditions and the constant efforts made to correct them. The popular mind responds to such novels as "Good-Bye, Doctor Roch."

THEODORE A. ANDERSON, M.D.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was held on January 12 at Children's Seashore House. The President, Dr. Josiah C. McCracken, Jr., presided.

The Secretary, Dr. John Holland, discussed elevation of members to regular status. Since the Falcone case, this is no longer an automatic procedure. Previously an Associate was promoted to member after one year. Under present practice, however, an Associate member must complete a new application to be approved by the State Society Credentials Committee. As they do not meet frequently, this takes considerable time.

Dr. Morton Leach read a letter on civil defense. In anticipation of atomic attack, it has been recommended to encourage teaching of medical self-help. This has been approved by the AMA. Dr. Morton Major then outlined the programs for the year: *October*: Panel Discussion on social security for physicians; *November*: Dr. Robert Block will speak on "Healing Processes of Tuberculosis;" *December*: Christmas Party; *January* 1963: Joint meeting with Woman's Auxiliary; discussion of "The Price Dilemma of Modern Medicine;" *February* 1963: Richard T. Smith will talk on arthritis; in *March*: Dr. Harold Lyons will serve as Visting Chief; *April*: Dr. Robert Ravdin will talk on Cancer Chemotherapy.

The Golden Merit Award this year will be presented to physicians who were graduated in the Class of 1912. Dr. Clarence Andrews will be one of the recipients. If any other physicians are eligible, the Secretary should be notified.

The Executive Committee had held a meeting prior to the regular meeting to discuss a letter received from Dr. David B. Allman, stating that his term as Trustee of The Medical Society of New Jersey expires in May 1962 and he is not eligible for re-election. We would like to have this position filled by another representative from Atlantic County.

Dr. Holland discussed opposition to Bill S.150 (of 1961). The New Jersey Society of Pathologists feel that S.150 is detrimental to physicians. The State Society has also written about the proposed Relative Value Index. Atlantic County has taken no action. This will be referred to a committee.

The Credentials Committee of the State Society has approved the application of Dr. S. Ronald Kline to be elevated to Regular membership. This was concurred in.

The members of the Auxiliary were then invited to join the meeting and Dr. McCracken introduced Mrs. Victor Ruby, President. Speaker for the evening was Mr. Leonard Rosenstein, co-owner of the Lincoln Pharmacy, past-president of the Atlantic-Cape May Pharmaceutical Association, and president-elect of the New Jersey Pharmaceutical Association. His subject was "The Price Dilemma of Modern Medicine."

The regular meeting of the *Medical Society of Atlantic County* was held on February 9 at the Children's Seashore House, with the vice-president, Dr. Morton Major, in the chair.

Dr. Clarence B. Whims introduced Dr. Richard T. Smith, Director of Rheumatology of the Benjamin Franklin Clinic of Pennsylvania Hospital. His topic was "Management of Gout." This well-presented paper was discussed by Dr. Whims.

Dr. Joseph Linsk spoke on the need of a Cobalt Unit for this area. In the light of newer information relative to the total cost and the obvious need and superiority of a Cobalt Unit over conventional x-ray therapy, it was felt that support of the entire medical community was merited. Dr. Morton Ritter also spoke on behalf of this unit. The Executive Committee will review this situation and report at the next meeting.

A resolution was read from Hudson County Medical Society stating that The Medical Society of New Jersey should assume responsibility for the mechanics of notifying an applicant of his election or rejection to membership.

The meeting was then adjourned, followed by a friendly hour of discussion and refreshments.

LEONARD B. ERBER, M.D.

Reporter

Cumberland

The February meeting of the *Cumberland County Medical Society* was held in the Cumberland Hotel Ballroom, Bridgeton, February 13, 1962 with Dr. Harry A. Reinhart of Millville, presiding.

Dr. Jack Lubin of Bridgeton and Dr. John A. Pastore of Vineland were unanimously accepted as active members.

The meeting was highlighted by the presence of Dr. Karl C. Jonas, Director of Surgery at Stetson Hospital, and editor of Babcock's *Principles of Surgery*. Dr. Jonas spoke informatively on "Diagnosis and Treatment of Carcinoma of the Colon and Rectum" to a most receptive audience of forty physicians.

LEONARD G. SCOTT, M.D.

Reporter

Essex

The *Essex County Medical Society* and the Essex County Bar Association held a joint meeting on March 8, 1962, to review some of the problems between the two professions. The first speaker, Mr. Abraham Harkavy, a practicing attorney, noted that physicians have an obligation to a patient under treatment to testify for him at "his day in court." He criticized doctors for being poorly prepared for trial; for bringing in too few records to support testimony; for speaking in terminology that is too technical; and for underestimating the medical knowledge of the opposing attorney. He also encouraged physicians to participate willingly in pre-trial conferences.

Dr. Henry A. Davidson listed the physicians' objections as being treated with disrespect during cross-examination; being badgered by the cross-examining attorney; and being asked to give an unqualified yes or no answer to hypothetical questions in which important facts have been deleted.

The Honorable Theodore J. Labrecque, Judge of the New Jersey Superior Court, assured the doctors that Judges try to cooperate with physicians by putting them on the stand without delay. He suggested that physicians maintain their dignity at all times; that they do not lose their tempers during cross-examination; and that they do not "talk down" to the jury. In rebuttal to the physicians' argument that calendar postponements upset their pre-arranged schedules, he stated that this was a problem that had to be faced by all parties concerned; and he recommended that physicians and lawyers resolve their differences by working together more closely.

HARVEY P. EINHORN, M.D.

Reporter

Hudson

With Dr. Nathan J. Plavin presiding, the regular meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center, on January 2, 1962.

The speaker of the evening was Dr. James E. McCormack, Dean of Seton Hall College of Medicine, whose topic was "Seton Hall Medical School and Its Influence on Medical Practice in the County."

Following the business meeting a collation was served.

CHARLES L. CUNIFF, M.D.

Reporter

Morris

The monthly meeting of the *Morris County Medical Society* was held on February 15 at the Warner-Lambert Laboratories, Morris Plains. This was the occasion for the annual Lathrop Lecture sponsored by our medical society and by the Morris County Heart Association. Dr. Arthur Grishman spoke on "Vector Cardiography." He discussed many aspects of this new modality, including its relationship to conventional electrocardiography.

Dr. John Kelly discussed the rules governing the Morris View Fund Nursing Home for welfare patients. He emphasized the need of close liaison between the referring physician and the physicians supervising the care of these elderly patients.

Dr. M. H. Mufson, Chairman of the Public Relations Committee, played a tape of a broadcast which radio station WMTR intends to present on a daily basis and have sponsored. This program has been given the approval of the AMA. Our County Society also gave its approval pending acceptance by the sponsor.

The meeting was adjourned by 10:45 p.m.

MONROE H. MUFSON, M.D.

Reporter

Passaic

The regular monthly meeting of *The Passaic County Medical Society* was held on January 16 at the Alexander Hamilton Hotel in co-sponsorship with the Passaic County Pharmaceutical Association.

The following were elected to Active membership: Drs. Vincenzo Abate, Edward Bradley, William H. Bristow, Carlos M. Cane, Nayade G. Cane, Vincent J. Del Giudice, Basil G. Dibsie, Sidney Fink, Arganey L. Lucas, Jr., Joseph A. Raso, Abe D. Stutchin and E. Robert Wilson of Paterson; Ralph N. Bloch and Eugene Bradley of Oakland; M. Merrell Bych of Passaic; Dean A. Wry, Jr. of Clifton; James A. Colfax and Victor J. Irmiere of Wayne; Nina J. Drazniowsky of Teaneck; Theodore Ch. Harami and Jerald M. Spivak of North Haledon; Emanuel Ignaccolo of Wyckoff and Saul L. Sanders of Butler. Elected to Associate membership were Drs. David Abed of Oakland, Seymour J. Eisner of Paterson, George D. Rovere of Wayne and Donald W. Delaney of Clifton.

A resolution was adopted on the retirement of Dr. Frederick P. Lee as Health Officer of Paterson.

Dr. Levine then turned the meeting over to Dr. Mitchel Bernstein of the Program Committee. Dr. Bernstein introduced Mr. A. Zobel, Director of Public Relations of Hoffmann-La Roche, Inc.; B. W. Carey, M.D., Medical Director, Lederle Laboratories; Jack Karel, M.D., Sr. Attending Pediatrician, St. Elizabeth Hospital and Mr. Frank Pinchak, R.P., Past-President, New Jersey Pharmaceutical Association. The subject for the evening was a panel discussion on "What Price Prescriptions" with W. Leonard Newman, Esq., of West New York, N. J., acting as moderator. A question and answer period followed.

At the conclusion of the program, a collation was served.

The regular meeting of the *Passaic County Medical Society* was held on Tuesday, February 20, 1962 at the Alexander Hamilton Hotel in co-sponsorship with the Passaic County Dental Society.

Dr. David Levine, president of the Passaic County Medical Society, first conducted a brief business session of the Society. Dr. Joseph C. Bamford, Jr., of Paterson, was elected to associate membership. Then a resolution on the death of Dr. Andrew B. Vanderbeek was unanimously adopted.

There was discussion about the possible relocation of our office.

A ballot was then distributed to the members and they were requested to indicate their preferred course of action:

(1) Sell our present property in Paterson, and purchase land in Clifton and erect a new building.
(2) Remain in our present location.
(3) Sell our property and rent offices.

After the ballots had been counted, it was found that the majority of members were in favor of remaining in our present location.

Dr. Levine turned the meeting over to Dr. Edward Wolfson, program chairman, who introduced Dr. Herbert Cole of the program committee who acted as moderator. Dr. Cole introduced Arthur G. Ship, M.D., D.M.D. and Milton Gero, D.D.S. Dr. Gero read a paper prepared by Reuben Feltman, D.D.S., who had been scheduled to speak but who was absent because of illness. Dental and medical aspects of fluoridation were presented. A lively floor discussion followed.

A collation was served following the adjournment of the meeting, with the Passaic County Medical Society as hosts.

ALEX E. SCHEFRIN, M.D.
Reporter

Salem

The February 16 *Salem County Medical Society* meeting was called to order at 4:40 p.m. by the President, Dr. William Sprout, at Richman's, Sharptown. Present were 23 active and 1 associate member. Dr. John S. Madara gave a report on the recent State Legislative meeting in Trenton. Dr. Sprout read a letter from E. G. Jacobs, M.D., Director of the Salem County Guidance Center, summarizing its activities for 1961 and asking for the support of the Society. The center now has a psychiatric social worker and last year treated 502 patients, 302 of whom were children. However, of this total, only 27 were referred by the local courts. Dr. Gilpatrick then introduced a resolution expressing appreciation of the society for the center and approval of its policies. This was unanimously passed.

Dr. Gilpatrick, after explaining the possibility of water-fluoridation at Upper Penns Neck and Penns Grove, moved that the society approve the basic philosophy of fluoridation. This was carried. Frank Winters, M.D., then discussed a matter concerning an automobile accident he treated at the hospital. The problem was referred for action to the Executive Committee.

Dr. Staub announced that the March guest speaker would be Harry Zinsken, M.D., Cardiologist, University of Pennsylvania, who would speak on "Surgery in Rheumatic Heart Disease." In April, the Chief Gastroenterologist at Graduate Hospital in Philadelphia will be our guest.

Dr. Axel Olsen, Professor of Neurosurgery at Hahnemann Medical College and Hospital, spoke on "Management of Head Injuries." At the conclusion of this most informative talk, a lively question and answer period followed. The meeting then adjourned to a delicious dinner.

JOHN T. DOOLEY, M.D.
Reporter

Medical Woman of the Year

Dr. Elizabeth R. Brackett of Nutley was honored last month as "Medical Woman of the Year" at a testimonial dinner at the Newarker Restaurant. The dinner was sponsored by the American Women's Medical Association. Dr. Brackett was brought up in Bergen County, New Jersey and in 1915 received an R.N. registration following training at New York's Presbyterian Hospital. After nursing corps service in France from 1917 to 1919, she entered Teacher's College in New York City, and in 1925 earned a B.S. degree; and the same year she was accepted at the College of Physicians and Surgeons (Columbia University). In 1929 she received her M.D. and interned at the Martland Medical Center. Then she did graduate work in pediatrics in Philadelphia Children's Hospital, later at Newark's Babies' Hospital.

Since then Dr. Brackett has been in private practice, serving in various grades at several hospitals in Essex County. She is Senior Attending at Presbyterian Hospital in Newark. She had a tour of duty as President of the New Jersey Chapter of the American Medical Women's Association, and has served in many civic posts in health, welfare and nursing work.

Announcements

Symposium on Headache

On Saturday afternoon, April 28, a symposium on headache will be held at the Statler-Hilton Hotel in New York City, under the auspices of the American Academy of Neurology. A star-studded faculty will present a series of brief but practical papers on the classification, diagnosis and treatment of this common complaint. For full details, write to Dr. Arnold Friedman at the Headache Unit of the Montefiore Hospital, Bainbridge Avenue, New York 67, N. Y.

Chicago Preview

The American Medical Association and the Atomic Energy Commission are sponsors of a meeting on Nuclear Medicine in Chicago June 24 to 28.

Theme of the overall annual meeting is "Medicine in the Atomic Age." All sessions and all exhibits are concentrated in Chicago's giant new convention hall, McCormick Place, on Lake Michigan. The program of the special joint meeting at the Chicago meeting is designed to enable the physician in practice to bring his knowledge of available nuclear diagnosis and therapy up to date.

Another major aspect of the Chicago meeting is a special general session on Mental Health. It is sponsored jointly by the AMA's Council on Scientific Assembly and on Mental Health. Participating sections are nervous and mental disease, general practice, and internal medicine.

A general session is also offered on teenagers' problems in medical practice. Participating sections are Pediatrics; Nervous and Mental Diseases; Obstetrics and Gynecology; Urology; Dermatology; and Orthopedic Surgery.

Inflammatory and Ulcerative Diseases of the Small Intestine will be the theme of a session with participation by the sections on Radiology; General Surgery; Internal Medicine; Gastroenterology and Proctology; and Physiology.

Neuropharmacology Lectures

You are welcome to attend a series of unusual lectures on the practical aspects of neuropharmacology and behavior influencing drugs. This seminar is held at the State Hospital at Ancora (Hammonton, N. J.) which is halfway between Camden and Atlantic City. The lectures are on Tuesday evenings at 7 p.m. Two-hour sessions are planned. The lecturer is Professor Walter W. Baker of Jefferson Medical College. If you do not know how to reach Ancora, write to Dr. H. H. Brunt, Ancora State Hospital, Hammonton, N. J., for driving instructions. The schedule follows:

April 17—Pharmacology of the Central Nervous System
April 24—Anticonvulsant Mechanisms
May 1—Antihistamines and Drug Reactions
May 8—Anti-emetics, Anorexics and Drugs in Equilibrium Disorders
May 15—Pharmacology of Alcohol and Insulin
May 22—Neurophysiology of Sleep, Sedatives and Hypnotics
May 29—Analgesics and Antipyretics
June 5—Pharmacologic Aspects of Drug Poisoning
June 12—Psychopharmacology and Placebo Actions of Drugs

Courses Sponsored by College of Physicians

All readers may be interested in three courses sponsored by the American College of Physicians. These seminars provide practicing physicians with current information on advances in internal medicine and related specialties. The following are announced:

May 14-16, Course No. 12, *Cardiology*: Wayne College of Medicine, Detroit; Richard J. Bing, M.D., Director, Minimal Registration, 40; Maximal Registration, 200.

May 21-25, Course No. 13, *Medical Neurology*: Harvard Medical School, Boston, Mass.; Raymond D. Adams, M.D., Director.

June 4-8, Course No. 14, *Psychiatry for the Internist*: School of Medicine, Baltimore; Ephraim T. Lisansky, M.D., Director.

For more details write to:

American College of Physicians, 4202 Pine Street, Philadelphia 4, Pa.

Obituaries • • •

DR. RICHARD P. BATTIN

At the untimely age of 45, Dr. Richard P. Battin died of a coronary attack on February 7. Dr. Battin received his M.D. at Yale in 1942 and interned at the Lakeside Hospital in Cleveland. He then entered the Navy, serving in the Pacific theatre during much of World War II. He then accepted a residency in obstetrics and gynecology at the Mary Imogene Basset Hospital in Cooperstown, New York. After doing additional graduate work in that specialty, he passed the American Board examinations and became a diplomate in obstetrics and gynecology. He entered private practice in Passaic, New Jersey and became affiliated with the Passaic General Hospital.

DR. HYMAN BORSHAW

While on vacation in Florida, Dr. Hyman Borshaw died suddenly on February 2. Born in New York City in 1897, Dr. Borshaw spent most of his life in New Jersey. In 1921 he received his M.D. degree at the College of Physicians and Surgeons (Columbia University) and after interning in Jersey City, he did graduate work in internal medicine and phthisiology. During World War II, he was lieutenant commander in the Navy Medical Corps. He was a Fellow of the American College of Physicians and was affiliated with all the hospitals in Jersey City. He was active in the Trudeau Association and in committee work for the Hudson County Medical Society.

DR. MARTIN J. McDONNELL

Following a brief illness, Dr. Martin J. McDonnell died on February 24. Born in Poughkeepsie in 1895, he received his M.D. at Fordham in 1920. Dr. McDonnell then had a brief period of service in the Army Medical Corps and in 1923 entered private practice in North Bergen. He served during World War II as a civilian medical examiner for the Selective Service System. He was an attending gastroenterologist at the North Hudson Hospital in Weehawken and he was active in the affairs of the Hudson County Medical Society.

DR. JOHN S. REITNAUER

Dr. John S. Reitnauer, a well-known Hudson County surgeon, died on February 19 after a long illness. Born in 1895, Dr. Reitnauer was graduated in 1920 from Bellevue Medical School, and interned at the Bellevue Hospital. He then moved to Hudson County and served the people of North Jersey for almost 40 years. Dr. Reitnauer was long affiliated with both the North Hudson Hospital and the St. Mary's Hospital of Hoboken, and at the time of his death was consultant in surgery at both institutions. A Fellow of the International College of Surgeons, he was active in the affairs of the Hudson County Medical Society.

DR. BENJAMIN SALWAY

At the untimely age of 55, Dr. Benjamin Salway died suddenly of a heart attack on March 3. A Rutgers graduate, Dr. Salway received his M.D. at Bellevue in 1931. After interning at St. Francis Hospital in Trenton, he did graduate work in general surgery, becoming a Board diplomate in that specialty in 1952. He was also a Fellow of the American College of Surgeons and was an attending surgeon at Trenton's Orthopedic Hospital and an Associate in Surgery at St. Francis. Dr. Salway was active in the affairs of our Mercer County Medical Society.

DR. GRENELLE B. TOMPKINS

On February 27, Hunterdon County lost its senior practitioner with the death that day of Dr. Grenelle B. Tompkins at the age of 78. Born in Bloomingdale, he received his M.D. from Columbia University in 1908. He took an internship then (an uncommon practice before 1912) and came to Flemington in 1911. He was a well-known and much beloved horse and buggy doctor in central Hunterdon County from 1911 until he acquired an automobile in 1921. He had the first x-ray equipment in the county—installed in 1922. Dr. Tompkins was an amateur musician of some note, being known in private circles as a gifted organist.

The 196th Annual Meeting

of

The Medical Society of New Jersey

Saturday-Wednesday, May 12 - 16, 1962

HADDON HALL, ATLANTIC CITY

Daily Schedule

Friday, May 11, 1962

5:00 p.m.—Board of Trustees

Saturday, May 12, 1962

10:00 a.m.—Registration Opens

2:00 p.m.—House of Delegates

3:30 p.m.—Golden Merit Award Ceremony

4:00 p.m.—Open Discussion on Medical-Surgical Plan

6:00 p.m.—Board of Trustees' Dinner (by invitation only)

8:30 p.m.—Nominating Committee

Sunday, May 13, 1962

11:00 a.m.—Reference Committee

1:00 p.m.—Exhibits Open

2:00 p.m.—Motion Picture Theatre

2:30 p.m.—House of Delegates (election)

5:00 p.m.—Essex County Reception (by invitation only)

5:00 p.m.—Union County Reception (by invitation only)

9:00 p.m.—Presidential Reception

10:00 p.m.—Dancing

Monday, May 14, 1962

9:30 a.m.—House of Delegates

9:45 a.m.—Motion Picture Theatre

2:00 p.m.—Motion Picture Theatre

7:00 p.m.—Dinner-Dance

Tuesday, May 15, 1962

9:00 a.m.—Board of Trustees

9:30 a.m.—Scientific Sessions:
- Cardiovascular Diseases
- Clinical Pathology
- Medicine and Rheumatism
- Obstetrics and Gynecology, and Urology
- Orthopedic Surgery

9:45 a.m.—Motion Picture Theatre

12:30 p.m.—Luncheons:
- New Jersey Branch, American Medical Women's Association
- Section on Chest Diseases, and New Jersey Chapter, American College of Chest Physicians
- Section on Orthopedic Surgery, and New Jersey Orthopaedic Society
- Section on Rheumatism
- Section on Surgery, and New Jersey Chapter, American College of Surgeons

2:00 p.m.—Motion Picture Theatre

2:00 p.m.—Scientific Sessions:
- Allergy and Pediatrics
- Anesthesiology, Chest Diseases, and Surgery
- Dermatology
- Psychiatry and Neurology

6:00 p.m.—Technical Exhibitors' Reception-Buffet

9:00 p.m.—Music and Dancing

Wednesday, May 16, 1962

9:30 a.m.—Scientific Sessions:
- Gastroenterology and Proctology, and Radiology
- General Practice and Metabolism
- Ophthalmology
- Otolaryngology

9:45 a.m.—Motion Picture Theatre

12:30 p.m.—Luncheon—Section on Radiology, and Radiological Society of New Jersey

1:00 p.m.—Exhibits and Registration Close

1:00 p.m.—Luncheon—Sections on Ophthalmology and Otolaryngology, and New Jersey Academy of Ophthalmology and Otolaryngology

Dinner-Dance

Monday Evening, May 14, 1962

7:00 p.m.

honoring

PRESIDENT AND MRS. RALPH M. L. BUCHANAN

Toastmaster

Richard I. Nevin, Executive Officer
The Medical Society of New Jersey

Welcome

Mrs. Floyd D. Gindhart, President, Woman's Auxiliary

Introductions

Mrs. John J. Torppey, President-Elect, Woman's Auxiliary

Louis S. Wegryn, M.D., President-Elect

Official Guests

Presentations

Fellow's Key

To: Ralph M. L. Buchanan, M.D., President

By: Jesse McCall, M.D., Immediate Past-President

Fellowette's Pin

To: Mrs. Floyd D. Gindhart, President, Woman's Auxiliary

By: Ralph M. L. Buchanan, M.D., President

Entertainment

Lafayette College Choir

Dancing

Haddon Hall Orchestra

House of Delegates

President, Ralph M. L. Buchanan, M.D., Phillipsburg

Secretary, Marcus H. Greifinger, M.D., Newark

Parliamentarian, Robert M. Backes, Trenton

Sessions

Saturday Afternoon, May 12, 1962

2:00 p.m.—First Session:

Invocation

Reverend Doctor C. Wayland James, First Presbyterian Church, Easton, Pa.

Call to Order

Organization of the House

Transactions of 1961 Annual Meeting

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Resolutions

Proposed Amendments to the Constitution and Bylaws

New Business

Announcements

Sunday Afternoon, May 13, 1962

2:30 p.m.—Second Session:

Report of Nominating Committee

Election

Monday Morning, May 14, 1962

9:30 a.m.—Third Session:

Reports of Reference Committees

Unfinished Business

Installation of Incoming President

Inaugural Address

Adjournment

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

Reference Committees

Sunday Morning, May 13, 1962

11:00 a.m.

Reference Committee on Constitution and Bylaws

Report of the:

- Committee on Revision of Constitution and Bylaws

Amendments to Constitution

Amendments to Bylaws

Reference Committee "A"

Reports of the:

- President
- Board of Trustees
- Secretary
- Judicial Council
- Committee on Credentials
- Executive Officer

Reference Committee "B"

Reports of the:

- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund

Reference Committee "C"

Reports of the:

- Medical Service Administration
- Medical-Surgical Plan
- Medicare Program

Reference Committee "D"

Reports of the:

- Committee on Medical Defense and Insurance
- Committee on Medical Education
- Special Committee on Physicians Placement Service
- Special Committee on Retirement Plan for Physicians

Reference Committee "E"

Reports of the:

- Council on Legislation
- Council on Public Relations

Reference Committee "F"

Reports of the:

- Council on Medical Services and its Special Committees on:
  - Industrial Health
  - Workmen's Compensation

Reference Committee "G"

Reports of the:

- Council on Public Health and its Special Comittees on:
  - Cancer Control
  - Child Health
  - Chronically Ill and the Aging
  - Conservation of Hearing and Speech
  - Conservation of Vision
  - Maternal and Infant Welfare
  - Mental Health
  - Rehabilitation

Reference Committee "H"

Reports of the:

- Committee on Annual Meeting and its Subcommittees on:
  - Scientific Exhibit
  - Scientific Program
- Committee on Honorary Membership
- Advisory Committee to the Woman's Auxiliary
- Special Committee on Disaster Medical Services
- Special Committee on Nursing Education
- Special Committee on Traffic Safety

Motion Picture Theatre

Sunday Afternoon, May 13, 1962-

Wednesday Morning, May 16, 1962

9:45 a.m.

External Cardiac Massage

James R. Jude, M.D., W. B. Kouwenhoven, Dr. Ing., and G. Guy Knickbocker, M.S.E., Johns Hopkins Medical Institutions, Baltimore, Md.

This film describes a recently developed technic whereby hearts that have stopped beating may be started again without opening the chest. An animation sequence illustrates how manual depression of the lower sternum compresses the heart, and forces blood into the pulmonary and systemic vessels. Release of pressure allows the chest to expand, and the heart to fill again. Combined with assisted ventilation, this method, begun within four minutes after cardiac arrest, assures the central nervous system of sufficient oxygen to prevent serious damage. *External Cardiac Massage* shows the steps that may be taken to resuscitate patients when heart arrest or ventricular fibrillation occurs *outside* the hospital as well as *inside* the hospital. The film distinguishes between heart arrest and ventricular fibrillation; illustrates the use of the external defibrillator as part of the resuscitation technic; features an interview with a successfully resuscitated patient whose heart had gone into ventricular fibrillation one year earlier; demonstrates the application of the procedure to infants and children; and discusses the various drugs as adjuncts to external cardiac massage.

10:15 a.m.

Essentials of the Neurologic Examination

Francis A. Vazuka, M.D., Assistant Professor of Neurology and Psychiatry; Director, Clinical Neuropsychopharmacology, Temple University Medical Center, Philadelphia, Pa.

The film shows how a good neurologic examination may be carried out without specialized equipment by physicians who are not neurologists. Animated sequences show the organization of the examination and the anatomy and function underlying it. In live action, a physician examines a patient with a relatively common neurologic disorder. He shows how he carries out the tests, and arrives at his diagnosis. The medical advisory committee which co-sponsored this film included: Russell N. DeJong, M.D., Chairman of Neurology, University of Michigan; A. L. Sahs, M.D., Professor of Neurology, University of Iowa College of Medicine; C. Knight Aldrich, M.D., Professor of Psychiatry at the University of Chicago; and John O. Milligan, M.D., Preceptor in General Practice at the University of Washington Medical School, and Chairman of the Committee on Mental Health of the American Academy of General Practice.

11:15 a.m.

Recognition and Management of Respiratory Acidosis

Reginald H. Smart, M.D., Hurley L. Motley, M.D., and Joseph F. Boyle, M.D., Cardio-Respiratory Laboratory, University of Southern California School of Medicine, Los Angeles, Calif.

This new film presents a clinic on a topic of wide interest in the medical profession. The course of a fatal case of respiratory acidosis is illustrated and discussed. The etiology and symptoms are examined in detail and the importance of early recognition emphasized. A suggested treatment program, including emergency treatment of acute cases, is outlined fully. The use of several types of pressure breathing apparatus is demonstrated with patients.

2:00 p.m.

Why Johnny Bleeds—Collaborative Diagnosis of a Hematologic Problem

Technical Advisor: John B. Miale, M.D., Miami, Fla.; Consultants: William D. Dolan, M.D., Arlington Va.; and Robert Kolvoord, Houston, Texas.

This film was sponsored by the Intersociety Committee on Pathology Information, which disseminates results of new research to physicians for practical application. The film is a good illustration of the importance of doing just that. There are areas in recent blood coagulation research which are just beginning to find clinical applica-

tion. Modern audiovisual educational methods are particularly suitable to bridge the gap between the results of research and their application to clinical problems. In this field, methods for pinpointing the diagnosis have been the outcome of recent research. The film emphasizes the role of the clinical pathologist to help the physician in the choice of laboratory procedures for diagnosing disease and in the selection of appropriate therapy. The film brings into focus the role of the medical technologist, who assists the pathologist by attending to many technical details and helping save some of his time. The problem presented in the little patient is well developed: one possibility after another has been eliminated until the dramatic moment when the differential diagnosis between hemophilia and so-called Christmas disease* has to be settled. The particular test capable of solving the riddle is used, and the answer is furnished.

2:25 p.m.

Nursery Sepsis

Produced for the American Academy of Pediatrics, American Hospital Association, and American Medical Association

The film demonstrates the problem of nursery sepsis including the role of the hospital, the carrier and the particularly susceptible infant. Attention is paid to highlighting the principal technics for preventing infections in the newborn.

3:00 p.m.

The Surgical Treatment of Mitral Stenosis by an Open Technique

Henry T. Nichols, M.D., Dryden P. Morse, M.D., and Gumersindo Blanco, M.D., Deborah Hospital, Browns Mills

The film shows the "open heart" technic for the relief of mitral stenosis by the left thoracic approach. It illustrates the placement of the right ventricular drainge catheter and the full opening of the anterior and posterior commissures. The removal and the debridement of calcium from the valve are also demonstrated.

**The designation "Christmas disease" comes from the name of the patient in whom the disease was first studied.*

3:25 p.m.

Myasthenia Gravis

Introduced by Henry Viets, M.D., Chairman Emeritus, Medical Advisory Board, Myasthenia Gravis Foundation

This color motion picture is an epitome of 20 years of research on myasthenia gravis. As a result of information thus collected, certain facts (either not known or poorly understood in 1935 when the study began) have been disclosed. Thus, we now know that the disease is more common than formerly recognized; diagnosis may be confirmed by simple tests carried out in a physician's office; and treatment, in most instances, can be instigated and carried through by an alert physician in general practice. Myasthenia gravis, considered to be 80 per cent fatal in 1935, now carries a death rate of 20 per cent or less if adequate and continuous medication is given. Most patients live a near normal life with expectancy not curtailed, if they are maintained under appropriate oral medication. Thus, the *gravis* has been in a large part removed from "myasthenia gravis."

The myasthenic patient should be cared for primarily by the general practitioner, with aid from a specialist in internal medicine or neurology in cases presenting a questionable diagnosis or requiring special treatment.

This film spells out the basic principles of diagnosis and treatment so that newer concepts can be accepted and incorporated into practice. Cases await the diagnostic skills of physicians, alert to the possibility that they may find a new patient in everyday routine. Or they may help an old one, already under care, but undiagnosed because this once rare disease did not come quickly to mind when the patient was first seen. Physicians can now prolong the life of a myasthenic, prevent invalidism, and give patients with this disease hope for a better future, a privilege not vouchsafed to their predecessors of 20 years ago.

3:50 p.m.

Conization of the Cervix

James H. Ferguson, M.D., and J. Allen Offen, M.D., The University of Miami School of Medicine, Coral Gables, Fla.

This film shows the use of cold conization of the cervix as a diagnostic aid and gynecologic procedure. It is a practical technic with maximum hemostasis having a low incidence of complication. This method was developed at, and is used by, the University of Miami School of Medicine.

Film program arranged and presented through the cooperation of Smith Kline & French Laboratories, Philadelphia, Pa.

Scientific Exhibits

Exhibit Hours

1:00 p.m. - 5:00 p.m., Sunday, May 13, 1962
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 14 and 15, 1962
9:00 a.m. - 1:00 p.m., Wednesday, May 16, 1962

Booth S-201. Common Vascular Brain Syndromes—Nicholas Panin, M.D., Alfred Ebel, M.D. and Milton Holtzman, M.D., Physical Medicine and Rehabilitation Services, Veterans Administration Hospitals, East Orange, and Bronx, N. Y.; and Welfare Island, N. Y.

The illustrations and diagrams presented in the exhibit on "Common Vascular Brain Syndromes" show the vascular supply of the brain and brain stem, and the location of the cranial nuclei. They have been prepared to show the relationship between lesion and syndrome as an aid to the clinician in arriving at a correct anatomic diagnosis. Since one of the aims is simplicity, only the commonly encountered complexes are presented.

Booth S-202. Demethychloretracycline—A New Broad Spectrum Antibiotic, Chemistry, Pharmacology, and Clinical Experience—William M. Sweeney, M.D., Stanton M. Hary, M.D., James M. Ruegsegger, M.D., Albert C. Dornbush, M.S., Jerry R. D. McCormick, Ph.D. and Newell O. Sjolander, Ph.D., Pearl River, N. Y.

Different sections of this exhibit are concerned with: (1) A comparison of the chemical structures of various tetracyclines; (2) Bacterial sensitivity testing for DMCT by both tube dilution and agar plate methods; and (3) Human pharmacologic studies. Also summarized are the clinical responses following DMCT therapy of more than 7,000 patients suffering from a wide variety of infection.

This is an extension of the study exhibited in 1961, expanded to include further studies of human pharmacology.

Booth S-203. Left Heart Catheterization—Peter P. Poulos, M.D., Elizabeth Johnson, M.D., David Chu, M.D., John H. Donnelly, M.D., Robert Pocelinko, M.D. and Jerome L. Mathias, C.R.T., Heart Institute, Presbyterian Hospital Unit, United Hospitals of Newark, Newark

Here is a pictorial representation of the transseptal, direct left ventricular puncture and arterial retrograde approaches to the left ventricle. A summary of the analysis of the last 100 cardiac catheterizations emphasizing the value of left heart catheterization in making an accurate and complete diagnosis. A correlation of the clinical, physiologic and cine-angiocardiographic findings in selected cases will be presented.

Booth S-204. Angiotensin—New Therapeutic Agent—Benjamin Jablons, M.D., Loreto S. Santiago, M.D., Maria Kolak, M.D., Agapito Del Rosario, M.D. and Paquita F. Manulat, M.D., Goldwater Memorial Hospital, New York, N. Y.

Angiotensin II amide, a synthetic valine 5, octapeptide, pharmacologically identical with natural angiotonin, is the most potent pressor agent available to date, as it is 8 to 10 times as potent as norepinephrine. The first panel of the exhibit presents a short summary of the historical development of the renal pressor system. The second panel illustrates the skin reaction to angiotensin and the difference in the duration of the skin test in normotensives as compared with hypertensives, treated or untreated. The difference in the type of reaction produced by other pressor agents is also shown. Remaining panels show the response to intravenous infusions of angiotensin in normotensives and in cases of shock due to various causes, and the angiotensin skin tests in these cases. The last panel carries a summary of our studies with angiotensin II amide.

Booth S-205. Evaluation of a New Respiratory Stimulant—Murray Miller, M.D., Philadelphia, Pa.: and Robert Nims, M.D., West Haven, Conn.

This study demonstrates the clinical pharmacology of ethamivan, a new ventilatory stimulant. The exhibit is divided into three sections: Section I demonstrates the theoretical concepts of ventilation with the respirogram demonstrating normal ventilation, the effects on ventilation in breathing 10 per cent carbon dioxide, the effects of niketha-mide on ventilation, and ethamivan on ventilation. Section II demonstrates the clinical effects, dose response curve, and EEG changes of ethamivan stimulated respiration on normal subjects. Section III demonstrates the clinical conditions in which this material is effective with appropriate case histories.

Booth S-206. The Contribution of Phonocardiography to Clinical Medicine—Bernard L. Segal, M.D., Daniel Mason, M.D., William Likoff, M.D. and Norman Burke, The Hahnemann Medical College and Hospital, Philadelphia, Pa.

The graphic illustrations of heart sounds have greatly facilitated the accuracy and understanding

of auscultation. Photographic and direct writing phonocardiograms will be demonstrated with the simultaneous tape recording through audiophones. There will be a discussion of various congenital and acquired heart lesions encountered in clinical cardiology. The auscultatory events will be interpreted in the light of the hemodynamics findings.

Booth S-207. Pleural Effusions—Their Meaning and Management—J. Antrim Crellin, M.D. and Robert G. Trout, M.D., Presbyterian Hospital, Philadelphia, Pa.

Pleural effusions occur from early infancy into the geriatric age. Their causes are many and varied but all are important. This exhibit will deal with the problem of effusions of all types, their etiology and incidence. Each one should be approached with a sound, rational plan to determine the cause and to institute proper therapy. A step-wise plan for management of pleural effusions is presented. The various tests that should be employed, their significance and reliability will be discussed. Proper management as far as therapeutics is concerned will also be presented in a graphic manner. Unfortunately some are unduly baffled by the presence of an unexplained pleural effusion and it is hoped that this practical plan to be presented for management of such effusions will be of benefit to those to whom the exhibit will be presented.

Booth S-208. 300 Most Frequently Prescribed Drugs in New Jersey—Rutgers—The State University, College of Pharmacy, Pharmaceutical Extension Division, Newark

Shown in booth S-208 are the results of a monthly survey in New Jersey pharmacies tabulating prescriptions as written in New Jersey.

Booth S-209. Case Histories Illustrating Current Treatment of Hypertension—L. Floyd Hobbs, M.D., Alexandria, Va.

Three patients are studied in detail to determine a modus operandi for treating hypertension. These patients provide average data to consider in hypertension. They are prototypes of 100 patients used in evaluating drug therapy. The exhibit seeks to answer such questions as when to treat hypertension, when not, the most appropriate measures to be taken including analysis of their relative values. Drug therapy is discussed in this comprehensive exhibit on hypertension.

Booth S-210. Diagnosis and Management of A-V Heart Block—Robert Alan Keisman, M.D., Hunter S. Neal, M.D. and Martin H. Wendkos, M.D., The Lankenau Hospital, Philadelphia, Pa.; and Coatesville Veterans Administration Hospital, Coatesville, Pa.

Multiple aspects of the problem of A-V heart block are presented. These include classification of the varieties of A-V heart block; methods for the differentiation from each other, from congenital, acquired, partial, complete, organic, functional, permanent, and reversible varieties; methods in the treatment of the various types of A-V heart block and their complications; indications for the use of an implantable internal cardiac pacemaker and the electrical, medical and surgical problems which can occur during the operative and postoperative period in connection with the implantation, both in the experimental animal and in man. Also presented is a patient whose Adams-Stokes attacks in connection with complete A-V heart block have been completely abolished by successful implantation of a transistorized internal cardiac pacemaker. His cardiac rhythm is continuously monitored on the screen of an oscilloscope in the exhibit booth.

Booth S-211. A Bipolar Intracardiac Electrode for the Control of Stokes-Adams Syndrome in Complete Heart Block—I. Richard Zucker, M.D., Victor Parsonnet, M.D., Lawrence Gilbert, M.D. and Maxim Asa, Ph.D., Hemodynamics Department, Newark Beth Israel Hospital, Newark

A bipolar intracardiac electrode catheter can be inserted quickly and simply in the critically ill patient for the control of heart block. The technic of insertion, its proper positioning and indications for its use are shown. A summary of its clinical use in patients and its experimental use in animals will be given.

Booth S-212. Phonocardiography—Modern Concepts—Paul B. Jennings, M.D., Estelle E. Kleiber, M.D., Diego DeArmas, M.D., Ralph Lev, M.D. and Barbara Leone, M.T., St. Peter's General Hospital, New Brunswick

This exhibit outlines the methods and technic for recording the human phonocardiogram by external and internal methods. Although previously considered a highly complicated cardiac diagnostic procedure, phonocardiography is shown to be a test now routinely performed in cardiac diagnostic evaluation. Normal and abnormal phonocardiograms are shown and the equipment and technic demonstrated so that this valuable diagnostic facility may be utilized more often by the specialist or general practitioner.

Booth S-213. Juvenile Rheumatoid Arthritis—John J. Calabro, M.D., Evangelos Catsoulis, M.D., Carlo J. Nosenzo, M.D. and Felix Traugott, Seton Hall College of Medicine, and Jersey City Medical Center, Jersey City.

Juvenile rheumatoid arthritis makes up less than 5 per cent of all cases of rheumatoid arthritis with a peak age incidence at 2 and 3 and again at 6 and 7. This disease may be protean in its clinical manifestations, presenting as arthritis, fever of obscure origin, maculo-papular rash and retarded growth. Early diagnosis and effective treatment are vital factors in prognosis.

Booth S-214. Cancer Detection by Immunologic Methods—Jack G. Makari, M.D., Muhlenberg Hospital, Plainfield

The exhibit is composed of four sections. Section I emphasizes the problem of cancer detection—how early? Section II points out the basis for immunologic diagnosis—cancer antigens vs normal antigens. It also points out the advantages of detecting univalent antibodies and incomplete antigens as used by us as compared to the older methods aimed at detecting bivalent antibodies and complete antigens. Section III describes in a schematic way our cancer blood test based on the use of the Schultz-Dale reaction, which has been confirmed by scientists in Europe and here. Section IV depicts our most recent efforts to detect tumors by the use of a tumor skin test. So far more than 800 patients have been tested with it and it has proved highly effective as a screening procedure for tumors.

Booth S-215. Improved Results in Oral Carcinoma Using Precision Per Oral Cone Therapy—S. Gordon Castigliano, M.D. and C. Jules Rominger, M.D., Misericordia Hospital, and American Oncologic Hospital, Philadelphia, Pa.

This exhibit details results of over 17 years experience with precision per oral cone therapy using custom made cones in a variety of oral lesions. The five-year survival free of disease rate is higher in all categories than the collected end result statistics of the American Cancer Society in Stages I, II, and III. Over 500 cases of oral malignancy involving the tongue, floor of the mouth, buccal surface, retromolar area, gingiva, tonsil, hard and soft palate are analyzed. The local lesion was controlled in 70 per cent of cases and necrosis of the treated area was minimal.

Booth S-216. The Use of Isolated Perfusion in the Management of Advanced Malignancy—John M. Howard, M.D., Joseph G. Strawitz, M.D., Charles Wolferth, Jr., M.D. and Jack Pyensen, American Oncologic Hospital, and The Hahnemann Medical College of Philadelphia, Philadelphia, Pa.

This exhibit demonstrates isolation perfusion as used to augment cancer chemotherapy. Results of 50 such perfusions in pelvic malignancy, recurrent malignancy in extremities and the head and neck are described. Also demonstrated is prophylactic isolation perfusion in the surgical management of primary malignant melanoma. The exhibit shows the significant control of pain in recurrent pelvic malignancy and the regression of recurrent tumors in extremities. The indications for this technic in the management of advanced malignancy are listed.

The exhibit shows the simplicity of the perfusion method as done at Hahnemann. It demonstrates the use of single and double lumen catheters and the desirability of monitoring perfusion pressure with the double lumen catheter. A discussion of the radioisotope technic for monitoring perfusion loss is part of the exhibit.

Booth S-217. Chemotherapeutic Control of Cancer—Jeanne C. Bateman, M.D. and Harry N. Carlton, M.D., Washington, D. C.

Chemotherapeutic agents for cancer control must be tolerated by the patient over long periods of time, must possess a minimum of side effects and must be easy to administer. The exhibit in booth S-217 concerns the use of N N' N" Triethylenethiophosphoramide in 1000 cases of cancer treated and controlled for periods ranging from one month to six years.

Because of the absence of vesicant tissue action this drug could be injected into any part of the body. For maximum effect on neoplasms, intratumor injection is preferable. Other routes included intrapleural, intra-abdominal, intrapericardial, transvaginal, intrahepatic, intracerebral, intravenous and oral.

Solid tumors responding to chronic chemotherapy with triethylenethiophosphoramide included ovarian, mammary, uterine (adenocarcinoma) brain, salivary gland tumors. Rehabilitation and prolongation of useful life were achieved in patients with pancreatic, gastro-intestinal and bronchogenic tumors. Triethylenethiophosphoramide was particularly useful in certain types of lymphomas.

Chemotherapy in cancer may be used as: (1) a tumor sterilizing agent, (2) adjunctive therapy in operations for "inoperable" tumors, and for (3) the treatment of advanced or recurrent cancer.

Booth S-218. The Effect of Smoking on Pregnancy—Lewis E. Savel, M.D. and Edward Roth, M.D., Newark Beth Israel Hospital, Newark

This exhibit displays material on the effect of smoking on pregnancy: (a) On the onset of labor; (b) On the size of the baby. The findings suggest that smoking during pregnancy leads to smaller babies by interference with fetal nutrition.

Booth S-219. The Vacuum Extractor in Obstetrics—Theodore D. Spritzer, M.D., Dunellen, and Eva R. Sargent, M.D., North Plainfield

At booth S-219 is a display of the Malmstrom Instrument and the exhibitor's modified instrument. Charts are shown indicating experience in 150 or more cases. Photographs of instruments in use are on display.

Booth S-220. Fluphenazine with Pyridoxine Therapy of Emesis Gravidarum—Joseph J. Price, M.D. and Michael C. Barry, M.D., Misericordia Hospital, Philadelphia, Pa.

Prenatal patients with a history of nausea and vomiting were given either placebo or identically appearing repeat-action fluphenazine with pyridoxine tablets in random order. Details are displayed in the exhibit in booth S-220. The effectiveness of fluphenazine therapy was evaluated by comparing the intensity of symptoms during treatment with those in the week prior to treatment.

The data on 31 treated with fluphenazine and 38 treated with placebo have been subjected to sta-

tistical analysis. This indicates a significantly greater effectiveness of fluphenazine than the placebo in the relief of prenatal nausea and vomiting. The charts and tables indicate the details of the statistical analysis, recording of data and placebo responses.

Booth S-221. Temporal Bone Banks Program—Walter A. Petryshyn, M.D., Montclair; Medical Coordinator, Deafness Research Foundation, New York, N. Y.

The problems of deafness have been difficult to solve because of the great lack of histo-pathologic material with correlated clinical findings. The Temporal Bone Banks Program, sponsored by the American Academy of Ophthalmology and Otolaryngology and supported by the Deafness Research Foundation, has been developed to fill this need. The Temporal Bone Banks receive, process and study temporal bones which have been willed and donated for research. This exhibit explains how temporal bones can be donated and where the temporal bone banks are located. A continuous movie will demonstrate the technic of removal of the temporal bones.

Booth S-222. Open System Halothane Anesthesia in Tonsillectomy and Adenoidectomy—Michaele L. LaPorta, M.D. and H. Walter Evans, Jr., M.D., Fitkin Memorial Hospital, Neptune

Booth S-222 has an exhibit displaying the use of Halothane *via* insufflation piece of Davis-Crowe mouth gag or nasotracheal tubes and permitting use of electrocauter for hemostasis. The technic is safe, pleasant for patient, complication-free. Surgical time has been cut 25 to 50 per cent.

Booth S-223. Ultra Sound Therapy of Vertigo—Martin Spector, M.D., Temple University School of Medicine, Philadelphia, Pa.

The exhibit shows the application of ultrasound in the treatment of vertigo, particularly Meniere's disease. An operating aural microscope is set up with temporal bone specimens so that visitors see the operative site magnified as the operator sees it. The ultrasound machine is demonstrated. Placards describe the otologic diagnosis of Meniere's disease and the indications for ultrasound operation.

Booth S-224. Reconstruction of the Soft Palate—Edgar P. Cardwell, M.D., United Hospitals of Newark, Newark

The exhibit shows in detail the only cases of extensive malignant surgery of the back of the mouth and tongue, including the soft palate in which reconstruction of the palate had been accomplished. Results have been understandable speech without prosthetic devices and the ability to eat comfortably. Graphic illustrations show the technic. Transparencies display a cadaver dissection, illustrating the types of lesions resected and the pre- and postoperative pictures of all patients. Postoperative results in the palate are illustrated by color transparencies. There is a recording of the postoperative voices of the patients and a functioning model of a skull showing where the tissues were removed and the reconstruction.

Booth S-225. Extra-Corporeal Circulation—Newer Applications—Ralph Lev, M.D., Paul B. Jennings, M.D., Estelle E. Kleiber, M.D., Diego DeArmas, M.D. and Barbara Leone, M.T., St. Peter's General Hospital, New Brunswick.

This exhibit portrays in concise outline form the principles, indications and results of the use of extra-corporeal circulation in more recent applications of this modality. Examples are shown of the recent advances in its use in cardiac surgery, vascular surgery and tumor perfusion. Personal experiences at St. Peter's General Hospital Cardio-Vascular Unit and Surgical Research Laboratory are exemplified.

Booth S-226. Severe Cleft Lip, Cleft Palate—New Technic in Preparing for Repair—John C. Walker, Jr., M.D. and Michael B. Collito, D.D.S., Babies' Hospital Unit, United Hospitals of Newark, Newark

The infant with the wide cleft lip with prominent premaxillary segment presents the greatest challenge to the rehabilitation team. Excessive scar tissue formation resulting from wide undermining at time of lip repair introduces the first inciting factor leading to maxillo-facial disharmonies in the growing child. To control the development of severe dento-facial handicaps the technic here displayed is offered. Soon after birth, the prominent premaxillary segment is gently guided into its proper position in the maxillary arch. The reconstituted arch now presents a more favorable skeleton from which the dental units develop. The width of the alveolar cleft is reduced, which reflects itself in a narrowing cleft of the lip. This closure provides the surgeon with a more favorable environment for lip repair. Here surgery is conducted in the absence of any fracturing with a minimum of scar tissue production so that all parts of the maxillary complex may be given the opportunity to gain their full growth.

Booth S-227. Open Heart Surgery for Mitral Stenosis and Mitral Insufficiency—Henry T. Nichols, M.D., Dryden P. Morse, M.D., Gumersindo Blanco, M.D. and Alberto Adam, M.D., Deborah Hospital, Browns Mills.

This exhibit illustrates methods and results in open heart surgery for mitral stenosis and mitral insufficiency. From September 1959, to September 1961, routine open heart surgery for all patients with mitral stenosis resulted in an average mortality of 6 per cent in 141 primary operations. A continuous motion picture with sound audible through stethophones demonstrates the surgical correction of mitral stenosis and insufficiency.

The operative mortality has decreased steadily with improvements in bypass technic. Only three

deaths have occurred in the last 91 consecutive primary patients. These points are graphically illustrated in panels.

The dramatically different results of the open approach are illustrated on the right hand panel with charts, x-rays, electrocardiograms, phonocardiograms and catheterization data.

Booth S-228. Modified Continuous Caudal Technic with Mepivacaine Two Per Cent—Irving M. Riffin, M.D. and Urban R. Finnerty, M.D., St. Vincent Hospital, Montclair

The exhibit shows a simplified method of doing a continuous caudal anesthetic. The anatomy and neuro-anatomy of the sacral hiatus and the peridural space are portrayed. The pharmacology of mepivacaine is elucidated. A graph of onset times of complete peri-anal anesthesia is shown. Results such as relaxation for proctologic surgery and other operative procedures for which this is amenable, ie., TUR, repair of cystocoele and rectocoele, surgery below mid-thigh, are discussed. The complete absence of reactions will be discussed.

Booth S-229. Electronarcosis—Gene L. D'Alessandro, M.D., Jordon Zwetkof, M.D., and Jesse Crump, M.D., Presbyterian Hospital Unit, United Hospitals of Newark, Newark

An appartus was designed to administer electric current of varying cycles by means of bitemporal electrodes in order to produce surgical anesthesia. In 100 experiments, there appeared to be no serious or permanent effects produced by electrical anesthesia. Pulmonary studies, ECG, EEG, blood gas analysis and blood ph were studied. The simplicity and safety of the apparatus is demonstrated. The possible value of this technic is discussed.

Booth S-230. Serial Accurate Blood Volume Determinations—C. Jules Rominger, M.D., Ward D. O'Sullivan, M.D., Richard H. Flandreau, M.D. and Horace Rosteing, M.D., Misericordia Hospital, Philadelphia, Pa.

This exhibit presents the usefulness of the Volemetron for serial accurate blood volume determinations using radioactive human serum albumin. With this portable instrument it is possible to do serial accurate blood volume determinations at any hour of the day or night, in any part of the hospital in 15 minutes. The equipment used is expendable; results are accurate and reproducable plus or minus four per cent even at the fifth determination and the procedure may be done by resident or technician without resort to calculations. The summary of our experience in over 500 determinations is presented.

Booth S-231. Aerosol Induced Sputum—An Efficient, Inexpensive Method, Utilizing 40 Per Cent Propylene Glycol in Isotonic Saline—J. Randolph Johnson, M.D., Burton M. Cohen, M.D., Carl Crandall, and Olga Sonin, Seton Hall College of Medicine, and Berthold S. Pollak Hospital for Chest Diseases, Jersey City

Artificial induction of cough for sputum production provides a convenient method for obtaining adequate deep cough specimens in patients with little or no cough, or with an unproductive cough. Hundreds of separate nebulizations were done at the B. S. Pollak Hospital with a variety of pulmonary diseases. Included were 64 patients subsequently proved to have bronchogenic carcinoma. The patients were classified, prior to inhalation exposure, into three groups according to their ability to spontaneously produce sputum. Group I consisted of patients with little or no cough. Group II comprised patients with unproductive cough. Group III were patients with adequate spontaneous cough. Results obtained will be represented graphically. Theoretical considerations will be presented. A demonstration of the apparatus in operation will also be included.

Golden Merit Award Ceremony

Saturday Afternoon, May 12, 1962

3:30 p.m.

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Presiding

Ralph M. L. Buchanan, M.D., President

Master of Ceremonies

John F. Kustrup, M.D., Chairman, Council on Public Relations

Marshals

Presidents of component societies whose members are receiving awards.

Scientific Section Meetings

Questions for Panel Members

Members of The Medical Society of New Jersey are urged to submit questions for presentation to and discussion by panel members who will participate in the following scientific programs.

Submit questions to the Society's Executive Offices—P. O. Box 904, Trenton 5, N. J.—and indicate the session and or speaker to whom each question is directed. The Executive Offices will forward the questions to the proper section officers.

Tuesday Morning, May 15, 1962

CARDIOVASCULAR DISEASES

JOSEPH M. STEIN, M.D., Chairman, Camden
HARPER K. HELLEMS, M.D., Secretary, Jersey City

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Anterior Chest Wall Pain

Moderator

Jerome G. Kaufman, M.D., Maplewood; Attending in Medicine, Newark Beth Israel Hospital, Newark

Orthopedics: Spinal Root Compression, Xiphoid Process Syndrome, Manubriosternal Syndrome, Cervical Rib, Costosternal Syndrome, Pectoral Syndrome, Herpes

Carl A. Maxwell, M.D., Chairman of Orthopedics, Morristown Memorial Hospital, Morristown

Attempt will be made to stress the usual and the commonplace and to suggest practical management. It must be remembered that pain referred to the anterior chest may originate in the lower cervical spine, lower cervical spinal nerve segments or in any thoracic nerve segment. Disturbance of the nerve roots (from whatever cause) may be felt most prominently in the anterior portion of the chest. The articulation of the clavicle with the sternum and the articulations of sternal components are frequently involved in arthritis. An automobile steering wheel is more rigid than the chest wall and is often the cause of trauma. The fractured rib which is so familiar as to be almost contemptible can be a source of major disability. Dr. Maxwell will discuss the commonplace and frequent rather than the exotic or rare.

Gastroenterology: Esophageal Lesions, Hiatal Hernia, Gastric Lesions, Cholelithiasis, Cholecystitis, Splenic Flexure Syndrome

Charles M. Thompson, M.D., Professor and Head of Section on Gastroenterology, The Hahnemann Medical College and Hospital, Philadelphia, Pa.

Anterior chest wall pain or discomfort may result from lesions of the esophagus, the stomach and duodenum; the gall-bladder, the ducts and the ampullary segment; the pancreas; and from syndromes that can result from aerophagy, or the magenblasse and splenic flexure syndrome. First consideration is given to the charactcristics of those developing in the esophagus, which is the most important site after the heart and lungs.

Gastric or duodenal ulceration may be associated with anterior chest wall pain. The commonest reason for this reference is penetration or uncomplicated increase in the painful stimulus or pain pathway overflow. Position of ulceration has a lesser role in the reference of pain to the chest. Involvement by penetration into hepatogastric ligament may be present.

Diseases of the gall-bladder are associated with anterior chest pain. This may be due to coincidental coronary artery disease. True visceral pain of great intensity arising in the gall-bladder or ducts is often referred to the region of the lower anterior chest in the region of the xiphoid. Pain in the left anterior chest may result from associated pancreatic edema.

Pancreatic edema and pancreatic necrosis may mimic the pain of left-sided pleuritis even being worse on respiratory excursion. A high incidence thrombo-embolism in pancreatic malignancy may account for chest pain in this lesion. The preponderance of the magenblasse and splenic flexure syndromes in the older patient with senescent cardiac changes compounds the difficulty in their recognition.

Features of these allied syndromes, which help to differentiate, are discussed. The tendency of these symptoms to be blended with those of heart disease is respectfully discussed.

Pulmonary: Pulmonary Embolism and Infarction, Tumors of the Lungs and Mediastinum, Mediastinal Emphysema, Pneumothorax, Pleurisy

Gustav A. Laurenzi, M.D., Assistant Professor of Medicine, Seton Hall College of Medicine, Jersey City

Experimental evidence indicates that the lung parenchyma, smaller bronchi, and visceral pleura are not sensitive to pain stimuli. This limits the usefulness of the absence of pain in evaluating a chest lesion. However, one can often predict that certain pulmonary lesions are extensive if they produce pain. This is especially true of bronchogenic carcinoma; chest pain in this disease is due to involvement of the large order bronchi, nerve roots, bone, or parietal pleura. Since the parietal pleura is sensitive, pain is commonly encountered in pleuritis, pneumothorax, pneumonia, and pulmonary infarction.

Cardiology: Myocardial-Ischemia, Angina, Infarction; Pericarditis, Aneurysms

Louis F. Albright, M.D., Spring Lake; Director, Department of Medicine, and Attending Cardiologist, Fitkin Memorial Hospital, Neptune

Cardiogenic chest pain properly includes pain originating in the myocardium, pericardium and thoracic aorta. Pain originating in the myocardium is usually referable to coronary artery disease and will be considered under three categories: angina pectoris, acute coronary insufficiency ("coronary failure") and myocardial infarction. This pain is a consequence of myocardial hypoxia. Pericarditis presents a challenge from the viewpoint of etiology, differential diagnosis and, to a lesser degree, treatment. Dissecting aneurysm presents the clinician with a real emergency with catastrophic possibilities. This discussion will be primarily concerned with the differential diagnosis of these conditions.

A flood of new laboratory tests including a seemingly endless procession of new serum enzymes, new electrocardiographic technics, new arteriographic procedures and radioisotope tests threaten to wash out the primacy of sound clinical judgment based on meticulous evaluation of the history and physical findings. Dr. Albright will emphasize the practical aspects of current concepts of differential diagnosis and critically examine the validity of some of the newer laboratory procedures. If time permits, a few minutes will be devoted to some of the more controversial aspects of treatment.

Psychiatry and Neurology: Psychosomatic Chest Pain

Harry H. Brunt, Jr., Medical Director, New Jersey State Hospital at Ancora, Hammonton

The diagnosis of psychosomatic chest pain is often made by elimination of organic causes. Even then the pain may be an early symptom of an underlying organic disease process which cannot be readily diagnosed. In patients with known organic pathology there may be increased pain due to the patient's personality.

The differential diagnosis must be made carefully through the psychiatric history, physical examination, laboratory tests, and, at times, the results of trial with therapeutic agents.

Treatment by certain psycho-chemical drugs or psychotherapy may be indicated once a definitive diagnosis is made. All psychiatrists are alert for organic disease, and being physicians, are able to diagnose them.

A discussion of the type of psychosomatic chest pain, its possible etiology and pathogenesis and some points on differential diagnosis will be included.

Question and Answer Period

11:45 a.m.

Visit to Exhibits

CLINICAL PATHOLOGY

Harry H. Stumpf, M.D., Chairman, Montclair
Marvin N. Solomon, M.D., Secretary, Vineland

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Select Aspects of Tumor Diagnosis and Their Clinical Implications

When is a Tumor Not a Tumor?

Hugh G. Grady, M.D., Professor and Chairman, Department of Pathology, Seton Hall College of Medicine, Jersey City

Morphologic appearances without reference to behavior of certain neoplastic-like lesions may be seriously misleading in attempting interpretation and prognosis. The lessons learned from the early experiences of the Bone Sarcoma Registry can be profitably applied to a number of tumor-like processes of current interest to surgeons and pathologists. A discussion of certain reactive or uncertain lesions masquerading as neoplasms will be presented.

10:10 a.m.

Malignant Change in Adenomas of the Colon, Its Clinical Significance

Horatio T. Enterline, M.D., Director, Surgical Pathology and Pathologic Anatomy, University of Pennsylvania Hospital, Philadelphia, Pa.

Sixty-one adenomatous polyps containing areas of carcinoma and 81 villous adenomas with and without carcinoma are reported. Fifty-five per cent of the villous adenomas contained invasive carcinoma and 13 of the 45 showed involvement of the regional lymph nodes. In the adenomatous polyps, the carcinoma varied from small areas to almost complete replacement of the polyps with involvement of the muscle coat of the colon. In no instance were the lymph nodes involved. However, 6 of 666 carcinomas examined showed residual areas of adenomatous polyp. In two of these cases lymph nodes were involved. The relationship of adenomas of the colon to carcinomas and the clinical implications are discussed.

10:40 a.m.

False Positive Cytologic Diagnoses

John F. Seybolt, M.D., Director, Papanicolaou Cytology Laboratory, The New York Hospital-Cornell Medical Center, New York, N. Y.

Dr. Seybolt will review various possibilities for rendering cytologic reports suggesting a malignant neoplasm in cases which cannot be shown to harbor cancer. The types of specimens to be considered will include those from the female genital, respiratory, gastro-intestinal, and genito-urinary tracts, as well as miscellaneous body fluids. Non-malignant pathologic conditions, faulty technic in the processing of specimens, and contamination probably constitute the chief factors leading to misinterpretation of cytologic preparations. Kodachrome slides will be projected to illustrate some examples of these.

11:10 a.m.

Non-Neoplastic Lymphadenopathy with Emphasis on Diagnostic Criteria

William G. Bernhard, M.D., Director of Pathology, St. Barnabas Medical Center, Newark

The diagnostic criteria for malignant lymphoma and non-neoplastic lymphadenopathy will be reviewed in some detail with illustrations of difficult non-neoplastic lymphadenopathy encountered by Dr. Bernhard in his years of experience. The discussion will center around these cases and will show how non-neoplastic lesions of lymph nodes may be confused with true tumors. Criteria will be outlined to help the pathologist in making this differentiation.

11:45 a.m.

Visit to Exhibits

MEDICINE AND RHEUMATISM

Joint Meeting

Medicine

William J. Snape, M.D., Chairman, Camden

Walter R. Edwards, M.D., Secretary, Trenton

Rheumatism

John J. Calabro, M.D., Chairman, Jersey City

Irving L. Sperling, M.D., Secretary, Maplewood

9:30 a.m.

Election of Officers

9:40 a.m.

Painful Joints as a Symptom in General Medicine

Edwin N. Murray, M.D., Chief of Medicine, The Cooper Hospital, Camden

Discussor: Irving L. Sperling, M.D., Newark

The proposition is "Study the patient; for all that hurts is not arthritis." Two cases of hepatobiliary disease are here presented in support of this proposition. One is a post-necrotic cirrhosis with joint pain. The other is a cholangiolitic hepatitis with joint pain.

10:10 a.m.

The Laboratory Animal and New Drugs

John C. Krantz, Jr., Ph.D., Professor and Head of Department of Pharmacology, University of Maryland School of Medicine, Baltimore, Md.

An avalanche of new drugs has descended upon the medical profession within the last decade. Eighty per cent of the drugs in general use in 1962 were unknown in 1952. Dr. Krantz will take the physician behind the scenes to the laboratory of the organic chemist and pharmacologist. The presentation will show how new drugs are conceived of and studied on laboratory animals. This scene has been changing with kaleidoscopic rapidity and has produced drugs that now affect every level of physiologic activity from cells to society.

10:40 a.m.

The Treatment of Gout

Richard T. Smith, M.D., Director, Department of Rheumatology, Benjamin Franklin Clinic and The Pennsylvania Hospital, Philadelphia, Pa.

Today we have a successful treatment for gout and gouty arthritis. Unfortunately, most gout victims are *not* receiving the protection and relief that adequate and up-to-date anti-gout therapy can provide. Correct diagnosis, modern therapy and patient cooperation are essentials of an effective program.

Dr. Smith's paper will show the need for early diagnosis and treatment; will point out that gout is not only a word to be heard; it is a disease that should be seen. This paper will demonstrate the great danger to health and even life which gout can cause; will emphasize that the morbidity can often be reversed or prevented. All of this means that the gouty individual can lead a normal life with modern anti-gout therapy.

11:00 a.m.

Symposium on Practical Considerations for Home Rehabilitation of Rheumatic Disease Patients

Moderator

William D. Kimler, M.D., Acting Rheumatologist, The Cooper Hospital, Camden

Panelists

Ronald Lamont-Havers, M.D., Medical Director, Arthritis and Rheumatism Foundation, New York, N. Y.

Joseph W. Still, M.D., M.P.H., Director of City of Camden Department of Health, Recreation, and Welfare, Camden

Peter W. Venace, M.D., Assistant Medical Director, Camden Municipal Hospital, Camden

11:45 a.m.

Visit to Exhibits

12:30 p.m.

Luncheon– Section on Rheumatism

Reservations: John J. Calabro, M.D., Seton Hall College of Medicine, Jersey City 4

OBSTETRICS AND GYNECOLOGY, AND UROLOGY

Joint Meeting

Obstetrics and Gynecology

Douglas W. Payne, M.D., Chairman, Asbury Park
F. Leland Rose, M.D., Secretary, Haddonfield

Urology

Herbert D. Axilrod, M.D., Chairman, Atlantic City
Harold Rubin, M.D., Secretary, Long Branch

9:30 a.m.

Election of Officers

9:40 a.m.

Urological Complications of Pregnancy

Samuel E. Kramer, M.D., Director of Urology, Perth Amboy General Hospital, Perth Amboy

Co-Author: Bernard M. Kramer, M.D., Perth Amboy

Discussor: Morris Gottlieb, M.D., Atlantic City

Dr. Kramer will discuss the urologic complications of pregnancy due to trauma during vaginal delivery, due to increased incidence of bacterial invasion of the functionally and mechanically dilated urinary tract, severe reversible impairment of renal function, severe reversible hypertension and due to acute renal failure from causes specific to gestation and surgical shock. The paper will also consider urinary calculus during pregnancy, pre-existing renal lesions such as hydronephrosis and pyonephrosis, and postpartum atony of the bladder. Case reports will illustrate the clinical approach to various urologic problems with special consideration of the viability of the fetus and the general condition of the gravid patient.

10:10 a.m.

Stress Incontinence

Hammell P. Shipps, M.D., Senior Attending Gynecologist, The Cooper Hospital, Camden

Discussor: Anthony R. Fernicola, M.D., Newark

Dr. Shipps will review urinary stress incontinence in women from the practical clinical standpoint of diagnosis and management. Details of the author's operative approach to the problem will be given. Some typical case records will be presented. Emphasis will be on long-term follow-up.

10:40 a.m.

Problems of Infertility

S. Leon Israel, M.D., Professor and Chairman, Department of Obstetrics and Gynecology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Discussor: Felix H. Vann, M.D., Englewood

The multiplicity of medical publications devoted to the subject, the widespread interest of the lay press, and pedagogic advances of the recent past have made most medical practitioners aware of the *sine qua non* of the proper management of infertility—complete systematic examination of each marital partner. This same universal awareness has focused attention upon problems that have their origin in our continued basic lack of understanding in the essential processes of fertility, that stem from the too facile resort to surgical correction of innocuous or unrelated conditions of the uterus, and that arise from the failure to use available diagnostic tools such as testicular biopsy and culdoscopy.

11:45 a.m.

Visit to Exhibits

ORTHOPEDIC SURGERY

James F. Collier, M.D., Chairman, Haddonfield
William J. D'Elia, M.D., Secretary, Spring Lake

9:30 a.m.

Election of Officers

9:40 a.m.

Problem Fractures About the Elbow in Children

Keith E. Haines, M.D., Attending Orthopedic Surgeon, The Cooper Hospital, Camden

Fractures in the region of the elbow are common in children and often present management problems. Supracondylar fractures of the humerus are the most frequent. Complications are discussed. These include embarrassment of circulation, radial nerve palsy and maintaining reduction. Fracture of humeral condyles and epicondyles and of the radial head and neck are reviewed because they are often troublesome. Careful follow-up care is needed to avoid growth deformities and fibrous ankylosis of elbow.

10:10 a.m.

The Limping Child

William J. D'Elia, M.D., Spring Lake; Director of Orthopedics, Fitkin Memorial Hospital, Neptune

Discussor: Joseph F. Raffetto, M.D., Asbury Park

Common among our younger patients is the child with a limp, often intermittent and not always accompanied by pain. Extremity pain in a growing child can be a cause of great concern. A painless limp is often considered a disorder of behavior, and thus may delay proper medical evaluation. Dr. D'Elia will discuss the common causes of limp, the growing epiphysis with avascular necrosis, differential diagnosis and general principles of treatment. Vague extremity complaints in children demand recognition and treatment, in the development of positive organic pathology to prevent subsequent disability.

10:40 a.m.

Hip Dysplasias in Children

John J. Reilly, Jr., M.D., Attending Orthopedic Surgeon, St. Elizabeth Hospital, Elizabeth

Dr. Reilly centers his paper on the necessity of early detection of hip dysplasias in children. The sooner after birth the condition is diagnosed and treated, the better the prognosis. If treatment is begun after one year of age, the prognosis is poorer and the ratio of poor results is increased. Representative x-rays will demonstrate this point.

11:10 a.m.

Foot Problems in Children

Daniel J. O'Regan, M.D., Assistant Attending Orthopedic Surgeon, Jersey City Medical Center, Jersey City

Discussor: Daniel M. Winters, M.D., Red Bank

Dr. O'Regan's presentation is based on the more common foot problems of children which may be seen in any doctor's office. Diagnosis and treatment will be outlined, with special emphasis on the need of small children for proper footwear.

11:45 a.m.

Visit to Exhibits

12:30 p.m.

Luncheon—Section on Orthopedic Surgery, and New Jersey Orthopaedic Society

Reservations: John M. Naame M.D., 1616 Pacific Avenue, Atlantic City

ALLERGY AND PEDIATRICS

Joint Meeting

Allergy

FRANK H. FELDMAN, M.D., Chairman, Newark
SYDNEY F. SMITH, M.D., Secretary, Highland Park

Pediatrics

MILTON PRYSTOWSKY, M.D., Chairman, Nutley
WILLIAM J. FARLEY, M.D., Secretary, Nutley

2:00 p.m.

Election of Officers

2:10 p.m.

The Relationship Between Hypogammaglobulinemia and the Allergic Diathesis

Arthur A. Goldfarb, M.D., Teaneck, Assistant Professor of Pediatric Allergy, Albert Einstein College of Medicine, New York, N. Y.

Do patients with agammaglobulinemia and hypogammaglobulinemia suffer from frank clinical allergy? Are there confirmatory skin tests?

Clinical major allergy occurred in a higher frequency than was expected in all three of the family groups studied, that is, (a) the congenital agammaglobulinemias, (b) the acquired hypogammaglobulinemias, and (c) the moderate hypogammaglobulinemias.

Gamma globulin treatments decrease the number of infections in patients with low gamma globulin. Steroid therapy decreases the incidence of infection even more when it is used in conjunction with the gamma globulin in these patients.

Quantitative gamma globulin studies are warranted in allergic patients with a family history or personal history of frequent infections, rheumatoid arthritis, and/or sudden death in infant family members.

2:35 p.m.

Immune Globulin in Health and Disease

Edward C. Franklin, M.D., Assistant Professor of Medicine, New York University School of Medicine, New York, N. Y.

The immune globulins consist of three major structurally and functionally related proteins. These are 7S globulin, 19S globulin, and 1A globulin. In the normal subject, all contain antibody activity. They are all decreased in agammaglobulinemia, and increased in a variety of diseases. The mycloma proteins, macroglobulins and Bence Jones proteins are abnormal proteins closely related to them. The structural and functional properties of these proteins will be discussed.

3:15 p.m.

Problems of and Indications for Prophylactic Immunizations

Lewis L. Coriell, M.D., Research Director, South Jersey Medical Research Foundation, Camden

The indications, dosage and theoretical considerations will be presented for all available vaccines and for the use of passive protection in various diseases when immune serum or gamma globulin are of value.

4:00 p.m.

Question and Answer Period

4:15 p.m.

Visit to Exhibits

ANESTHESIOLOGY, CHEST DISEASES, AND SURGERY

Joint Meeting

Anesthesiology

EDWARD G. BOURNS, M.D., Chairman, Westfield
GEORGE E. COVINTREE, M.D., Secretary, Haddonfield

Chest Diseases

THOMAS C. DECECIO, M.D., Chairman, Cliffside Park
THOMAS J. ORMSBY, M.D., Secretary, Newark

Surgery

WAYNE W. HALL, M.D., Chairman, Paterson
RAYMOND E. BANTA, M.D., Secretary, Ridgewood

12:30 p.m.

Luncheons:

Section on Chest Diseases, and New Jersey Chapter of American College of Chest Physicians

Reservations: Thomas C. DeCecio, M.D., 691 Palisade Ave., Cliffside Park

Section on Surgery, and New Jersey Chapter, American College of Surgeons

Reservations: Benjamin Daversa, M.D., 209 Passaic Ave., Spring Lake

2:00 p.m.

Election of Officers

2:10 p.m.

Penetrating Wounds of the Lung

John J. McGuire, M.D., Attending Thoracic Surgeon, The Presbyterian Hospital, Newark

2:18 p.m.

Contusions of the Lung

James B. Cummins, M.D., Associate Surgeon, Morristown Memorial Hospital, Morristown

The physiology and pathology of the contusion of lung, also called "Wet Lung Syndrome" is discussed, as well as massive collapse or atelectasis, blast injury and traumatic asphyxia. The associated intra-thoracic injuries (such as laceration of the lung, pulmonary artery of the brain, repair of the bronchus) are presented. Associated physiology and anatomic changes are reviewed. Dr. Cummins will also discuss treatment.

2:26 p.m.

Stove-in Chest

Michael R. Romundo, M.D., Paterson; Attending Thoracic Surgeon, Passaic General Hospital, Passaic

Two per cent of all auto injuries have crushed chest. The importance of recognizing this is obvious. It requires a careful and orderly plan of management. This allows for the greatest salvage of an extremely critical group of patients.

This presentation reviews the physiology of the chest and the effect on it of injuries. It outlines a plan for the reorganization and institution of therapy.

The details of management with a discussion of all of the facets of each regime are presented as they pertain to: (1) Patency of airway; (2) Control of intrapleural tension; (3) Relief of pain; (4) Management of shock; (5) Stabilization of the chest wall and (6) Exploration of chest as indicated.

2:34 p.m.

Injuries to the Esophagus

Charles E. Clark, M.D., Associate Attending Surgeon, The Valley Hospital, Ridgewood

Dr. Clark discusses injuries of the esophagus resulting from external violence, instrumental injury, foreign bodies, spontaneous perforations and chemical burns. Included will be a review of the anatomic factors in the susceptibility and resistance of the esophagus to injury and their relationship to methods of correction.

Diagnosis and prevention of the injury are outlined. The management of the condition together with its complications and sequellae are mentioned.

2:42 p.m.

Penetrating Wounds of the Heart

Peter P. Poulos, M.D., Attending Surgeon, The Heart Institute, United Hospitals of Newark, Newark

The diagnosis of penetrating wounds of the heart should be based upon the history and clinical examination of the patient. Cardiac tamponade will produce a falling arterial pressure, a rising venous pressure, and a small, quiet heart. Occasionally, one or two aspirations of the pericardial sac may be all that is necessary. Tamponade is unlikely to develop if there is a large pericardial tear. In general, thoracotomy should be performed and is indicated if there is continued intra-thoracic bleeding, or suspected penetration of cardiac chambers.

2:50 p.m.

Anesthesia Problems in Chest Trauma

In the Operating Room

Joseph A. Cox, M.D., Elizabeth; Director of Anesthesia and Attending Anesthesiologist, St. Barnabas Medical Center, Newark

The physician with specialized training in anesthesiology must quickly and expertly apply his knowledge of dynamic physiology to patients arriving in the operating room after sustaining major chest injuries. In addition, he must carefully administer the indicated pharmacologic agents and anesthetic technics to such seriously injured patients, usually with minimal preparation and background information. The proper approach in anesthetic management of these patients, in the face of such handicaps, is described in detail in this presentation.

In the Recovery Room

William H. Spencer, Jr., M.D., Short Hills; Assistant Attending Anesthesiologist, The Hospital Center at Orange, Orange

Dr. Spencer speaks of recovery room problems encountered in postoperative chest cases, with particular reference to situations unique to chest trauma. The management of flail chest receives special attention.

3:15 p.m.

Tracheostomy—Indications and Contra-indications

George N. J. Sommer, Jr., M.D., Thoracic Surgeon, St. Francis Hospital, Trenton

Tracheotomy is used in the treatment of thoracic injuries for two purposes, which are often com-

bined. One aim is to facilitate the removal of blood and tracheobronchial secretions that obstruct the airway. The second purpose is to aid respiration in the presence of severe injuries with paradoxical movement of the thoracic wall. This often requires external stabilization or better internal pneumatic stabilization with the Morch respirator.

3:23 p.m.

Reconstruction of the Esophagus

Henry J. Heimlich, M.D., Chief of Esophageal Surgery, Flower and Fifth Avenue Hospitals, New York, N. Y.

Replacement of the entire esophagus, from the hypopharynx to the stomach, has been accomplished by means of a "reversed gastric tube." The tube is contructed from the greater curvature of the stomach. It remains attached at the fundus, and is swung upward accompanied by its vascular supply, the left gastro-epiploic vessels. The antral end of the tube is anastomosed to the cervical esophagus or pharynx.

Patients suffering from cancer of the cervical or thoracic esophagus, or with strictures caused by lye, peptic esophagitis, or congenital lesions, are able to eat a regular diet postoperatively. The operation has been done on 21 patients during the past five years.

3:31 p.m.

Mechanism of Action of Closed Chest Cardiac Massage

Victor Parsonnet, M.D., Associate Surgeon, and Director of Vascular Research, Newark Beth Israel Hospital, Newark

Closed chest cardiac resuscitation has become a widely accepted technic for the treatment of cardiac arrest. Studies in animals seem to indicate that blood flow is obtained by the intermittent increase and release of overall intra-thoracic pressure, and not from direct compression of the heart itself. The clinical significance of this observation will be discussed, and a program for cardiac resuscitation presented.

3:39 p.m.

Summary

Emil A. Naclerio, M.D., Chief of Thoracic Surgical Service, Columbus and Harlem Hospitals, New York, N. Y.

The sudden and dramatic situations frequently encountered in acute thoracic trauma and their emergency treatment are briefly discussed. Dr. Naclerio also presents the different ways that chest injuries can be treated. These consist of three simple and practical methods of approach: one is on a physiologic basis, another on an etiologic, and a third on an anatomic basis.

3:47 p.m.

Round Table Discussion by Speakers

4:15 p.m.

Visit to Exhibits

DERMATOLOGY

Sol J. Fanburg, M.D., Chairman, Newark
John R. Tobey, M.D., Secretary, Newark

2:00 p.m.

Election of Officers

2:10 p.m.

Eruptions and The New Drugs

Herman Beerman, M.D., Professor and Chairman of Dermatology, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Because of the vast number of new drugs constantly being introduced, recognition of the drug factor in causing cutaneous reactions is often difficult. But this is of prime importance to the physician. The general background and clinical characteristics, including diagnosis and treatment of drug eruptions, will be detailed. Specific lesions attributable to certain of the new drugs will be considered.

2:55 p.m.

Changes in the Skin Diagnostic of Systemic Disease

Harold J. Jeghers, M.D., Professor and Director, Department of Medicine, Seton Hall College of Medicine, Jersey City

The skin is not an inert external covering of the body, It is, rather, an organ system in dynamic equilibrium with the internal organs. It reflects good general body health. Many systemic diseases cause changes in the skin, some of a generalized non-specific nature, others distinctive enough to suggest or (even be specifically diagnostic of) the internal disorder.

Observation of the skin is one of the simplest and most readily available methods of clinical examination. Detection of skin changes often suggests the diagnosis of a wide variety of systemic diseases. Some representative examples will be presented, illustrated by lantern slides in color.

3:35 p.m.

The Current Status of Radiation Therapy in Skin Diseases

Earle W. Brauer, M.D., Jersey City; Associate Clinical Professor of Dermatology, Post-Gradu-

ate Medical School, New York University Medical Center, New York, N. Y.

The atomic era has caused necessary readjustment in our thinking regarding the medical administration of ionizing radiation. At the same time, recent advances in drug therapy have significantly reduced the indications for radiation therapy. These two dynamic influences have created a revised position of responsibility for the practitioner which will be identified. The discussion will include new equipment and technics while stressing the positive role of the therapist.

4:15 p.m.

Visit to Exhibits

PSYCHIATRY AND NEUROLOGY

Ira S. Ross, M.D., Chairman, South Orange
J. Lloyd Morrow, M.D., Secretary, Passaic

2:00 p.m.

Election of Officers

Psychiatric Aspects of Living in Confined Quarters Under Atomic Attack

2:10 p.m.

Definition of Confined Quarters as Related to Atomic Attack

Conrad M. Knight, Radiologic Safety Officer, Duke University, Durham, N. C.

In August 1961 the Congress appropriated 93 million dollars for the survey and marking of existing buildings as fallout shelters available to the general population. Dr. Knight's paper will describe representative shelters located under this program, and will offer an explanation of the need for shelters and radiologic safety considerations related to fallout situations.

3:10 p.m.

Round Table Discussion

Psychiatric Problems

David J. Flicker, M.D., Attending Psychiatrist, Newark Beth Israel Hospital, Newark

Infant Care Problems

Edward P. Duffy, Jr., M.D., Belleville; Attending Pediatrician, St. Barnabas Hospital, Newark

Problems of the Aged

Paul Haun, M.D., Director of Psychiatric Education, New Jersey State Department of Institutions and Agencies, Trenton

The medical profession is dedicated to the treatment of the emotional and physical ills of mankind and to the preservation of human life. Our tradition of service to the preservation of life sends the medical corps to battle, unarmed, with a feeling of compassion to friend and foe regardless of political allegiance, race, color or creed. The lessons learned from yesterday's wars by the medical profession become the life-saving instruments of tomorrow's peaceful living. The solutions to the problems of wound contamination and contagious disease of the ancient battle hordes have become the mass immunization technics of today. Necessity has inclined the endeavor of the healing art from treatment to prophylaxis. Ambrose Pare in the 16th century saved the lives of more wounded soldiers with the suture and emollient oil than with the cautery. Pierre Lame saved enough lives by devising the field ambulance in Napoleon's army to make the ambulance as necessary an instrument of war as it is now an essential adjunct to civilian life on our hazardous highways. During the American Civil War the technic of attrition extended to civilian populations. The soldier boy on the battlefield was no longer the sole defender of his loved ones at home. Mental conflict was added to the hazards of infectious disease and wound infections. Prophylaxis for infectious disease did not develop quickly enough to prevent typhoid from killing more soldiers than bullets did in the Spanish-American War. By World War I, immunization prevented typhoid fever, tetanus and gas gangrene. Psychiatric casualties mounted then, however, and "shell shock" became a household term. By World War II, psychiatry had been forced to the forefront in medicine. The lessons then learned by the psychiatrist form the basis of psychiatric prophylaxis. Doctors Flicker, Duffy and Haun discuss both national and individual (mental health) implications of preparations for living in confined quarters under atomic attack. They review the psychiatric aspects of living in these quarters after atomic attack. Mr. Conrad Knight, Radiologic Safety Officer of Duke University, will set the stage by defining what may be anticipated as "viable quarters" in the event of atomic attack as contrasted to areas of total destruction of life.

At a time when as a nation we are called upon to face the prospect of oblivion to maintain our great principles, "a decent respect to the opinions of mankind" calls upon us to deliberate whether the morale and mental health of our nation are better served by waging our peaceful pursuits in constructive daily work or whether there is more to be gained by all-out preparation for life in shelter areas.

4:15 p.m.

Visit to Exhibits

GASTROENTEROLOGY AND PROCTOLOGY, AND RADIOLOGY

Joint Meeting

Gastroenterology and Proctology

URBAN R. FINNERTY, M.D., Chairman, Montclair
JACOB A. RIESE, M.D., Secretary, West New York

Radiology

NATHAN S. DEUTSCH, M.D., Chairman, Plainfield
LEONARD S. ELLENBOGEN, M.D., Secretary, Atlantic City

9:30 a.m.

Election of Officers

9:40 a.m.

The Early Diagnosis of Gastric Cancer

Philip J. Hodes, M.D., Chief of Radiology, Jefferson Medical College Hospital, Philadelphia, Pa.

The literature has stressed repeatedly the roentgen manifestations of benign gastric ulcer. As the result of this, many individuals in judging gastric lesions, bear in mind constantly the image of the benign gastric ulcer to the exclusion of intimate familiarity with the very early manifestation of gastric cancer. The latter will be described and demonstrated. Comment will also be made concerning the healing of ulcer and the test for determining the benign or malignant characteristics of a lesion.

10:10 a.m.

Symposium on Diarrhea

Radiologic Aspects

Benjamin Copleman, M.D., Director of Radiology, Perth Amboy General Hospital, Perth Amboy

Dr. Copleman will deal with the preparation of the patient and the opaque material to be used. The general conduct of the examinations will be discussed briefly. Most of Dr. Copleman's time, however, will be devoted to the demonstration and discussion of the more important diseases of the small and large bowel from the roentgenologic point of view.

Infectious Aspects of Diarrhea

Robert Horowitz, M.D., Attending in Gastroenterology, Jersey City Medical Center, Jersey City

Identification of the infectious agent in acute diarrheal disease is difficult. The nature of less than 50 per cent of these outbreaks can be established in even the best laboratory. Studies of infectious enteritis in nurseries indicate that pathogenic *E. Coli* is the most common *recognizable* cause. In the general population, the most frequent *known* cause of infectious diarrhea is acute enterotoxic staphylococcal gastroenteritis. Salmonella and Shigella account for a much smaller proportion. Certain viruses of the ECHO group have been found to cause dysentery in infants. In adults, viral gastroenteritis is strongly suspected but needs further classification.

Diarrhea Due to Organic Pathology

Ferdinand G. Weisbrod, M.D., Associate Attending in Gastroenterology, East Orange General Hospital, East Orange

Surgery for ulcerative colitis is being recommended in a large proportion of cases in spite of recent advances in medical treatment. This represents, however, a distorted picture since most of this literature is from the larger medical centers where the more severe cases are concentrated. A broad range of cases from the general community shows a trend toward *medical* management in an increasingly higher proportion of cases.

Medical and Surgical Management of Ulcerative Colitis

Eugene P. Salvati, M.D., Assistant Attending in General Surgery, Muhlenberg Hospital, Plainfield.

11:45 a.m.

Visit to Exhibits

12:30 p.m.

Luncheon—Section on Radiology, and Radiological Society of New Jersey

Reservations: George H. Burke, M.D., 601 Grand Avenue, Asbury Park

GENERAL PRACTICE AND METABOLISM

Joint Meeting

General Practice

GEORGE C. PARELL, M.D., Chairman, Newark
EDWARD M. COE, M.D., Secretary, Cranford

Metabolism

JOHN F. HINER, M.D., Chairman, Titusville
GABRIEL PICKAR, M.D., Secretary, Highland Park

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Diabetes and Obesity

The Effect of Antidiabetic Therapy on Various Lipid Measurements

Thomas J. Vecchio, M.D., Development Section of Clinical Research, The Upjohn Company, Kalamazoo, Mich.

Interest in the serum lipids in diabetes stems from three established correlations: (1) the increased incidence of atherosclerosis in diabetes, (2) the elevated serum lipids found in diabetes, and (3) the association between elevated serum lipids and atherosclerosis. Dr. Vecchio reviews the information available on the effect of conventional antidiabetic therapy on the serum lipids, as well as the effect of therapy directed specifically to the lipid abnormality, touching on the relationship between the lipid and carbohydrate abnormalities.

Present Status of Diabetic Management

Peter F. Maurice, M.D., Fellow in Medicine, Seton Hall College of Medicine, Jersey City

The horizons in diabetes mellitus are rapidly expanding. Attention today is being directed not only to the treatment of diabetes mellitus (with consequent prevention or delay in the onset of complications) but also to the detection and treatment of asymptomatic diabetics and pre-diabetics with the goal of preventing overt diabetes mellitus. Dr. Maurice will review recent experimental and clinical data which demonstrate that there be not only improvement, but even normalization of carbohydrate tolerance if therapy is instituted early enough when augmentation of pancreatic islet cell function is possible.

Obesity

Perry S. MacNeal, M.D., Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pa.

Dr. MacNeal will review the physical, dietetic, and emotional implications of obesity as it applies to diabetes mellitus. He will discuss the correlation of diabetes and obesity to general health and well-being.

11:45 a.m.

Visit to Exhibits

OPHTHALMOLOGY

HENRY ABRAMS, M.D., Chairman, Princeton
ALFONSE A. CINOTTI, M.D., Secretary, Jersey City

9:30 a.m.

Election of Officers

9:40 a.m.

Practical Fitting of Corneal Lenses

Frederick P. Sutliff, M.D., Instructor in Ophthalmology, Temple University School of Medicine, Philadelphia, Pa.

Dr. Sutliff will present methods for fitting and prescribing of corneal contact lenses. The indications and contra-indications, including patient selection, will be discussed. The speaker will outline methods of refraction, measurement of the cornea, and ophthalmometry. The writing of prescriptions from this information will be demonstrated. Instructions to patients on insertion and removal of corneal lenses and wearing-time schedules will be presented. Dr. Sutliff will also speak about the management of the patient's problems and follow-up visits.

10:05 a.m.

Problems in Fitting Contact Lenses

Donald A. Fonda, M.D., Ridgewood; Attending in Ophthalmology, Paterson General Hospital, Paterson

Dr. Fonda's paper considers several problems of contact lens fitting grouped as a symptom complex which the author terms "the corneal compression syndrome."

Perhaps the most prevalent and disturbing patient complaint is blurred vision through spectacles upon removal of contact lenses. This presentation explains the cause of this symptom and describes its objective signs. Dr. Fonda will outline the measures which should be taken to minimize or eliminate the problem.

10:30 a.m.

Ophthalmodynamometry—Practical Aspects of Its Relation to Vascular Insufficiency Syndromes

Robison D. Harley, M.D., Chief of Ophthalmology, Atlantic City Hospital, Atlantic City

The recognition of carotid artery occlusive disease has made ophthalmodynamometry a diagnostic procedure of considerable importance to all physicians and doubly to the neurosurgeon. This simple and readily reproducible method for measuring the retinal arterial diastolic and systolic pressure must be made available when symptoms indicate unilateral occlusive disease. Characteristically, carotid artery insufficiency may be suspected in intermittent blurring, transient vertigo or unilateral weakness.

Ophthalmodynamometric tests should be conducted supine and standing. In patients with cerebrovascular disease there is a greater fall in the ophthalmic artery on standing. Such a drop may occur in the absence of carotid insufficiency. However, the posture test has proved of value in detecting carotid insufficiency syndromes which might otherwise have been overlooked.

10:55 a.m.

Practical Application of Pleoptics

William Rubin, M.D., Chief of Ophthalmology, Middlesex General Hospital, New Brunswick

About five per cent of the population has one amblyopic eye due to strabismus. This means there are over nine million people with partly blind eyes in the entire country—having no organic disease. Changing the retino-cerebral response by foveal stimulation and by correcting foveal localization in space can be an effective approach to this problem. Fifteen non-selected children ranging from seven to seventeen years of age were treated at summer camp with pleoptic technics. Two-thirds of the group acquired better than 20/40 vision in the poor eye. Sixty per cent developed centric fixation in this eye and 40 per cent developed third degree fusion and stereopsis. When we realize that occlusion of the good eye (previously used in the treatment of amblyopia) was the only method employed, we must consider these newer technics of far reaching significance.

11:20 a.m.

The Roles of the Ophthalmologist and Orthoptic Technician in Pleoptics

Herbert M. Katzin, M.D., Attending Surgeon, Manhattan Eye, Ear, and Throat Hospital, New York, N. Y.

Assisted by: Geraldine Wilson, R.N., New York, N. Y.

Pleoptics is a systematic method of analyzing and treating functional amblyopia, especially amblyopia with faulty fixation patterns. The intensive treatment, advocated by European "pleoptic schools," requires specially trained personnel and well equipped rehabilitation centers. This arrangement is not always practical for the ophthalmologist in this country.

The important role that this new discipline should and can play in analysis of cases will be stressed. Dr. Katzin will describe the technics and will evaluate the information needed to answer the questions how to treat and when to treat. Several case studies will be presented to illustrate how valuable a tool pleoptic analysis is to the ophthalmologist, orthoptist and to the patient.

11:45 a.m.

Visit to Exhibits

1:00 p.m.

Luncheon—Sections on Ophthalmology and Otolaryngology, and New Jersey Academy of Ophthalmology and Otolaryngology

Reservations: Mr. Randall Norris, 367 New Bridge Road, Bergenfield

OTOLARYNGOLOGY

Arthur Dintenfass, M.D., Chairman, Atlantic City
Aris M. Sophocles, M.D., Secretary, Trenton

9:30 a.m.

Election of Officers

9:40 a.m.

Symposium on Microsurgery of the Middle Ear—Stapes Operation and Tympanoplasty

Moderator

Bernard J. Ronis, M.D., Professor of Otolaryngology, and Chairman, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Panelists

Sidney S. Boyers, M.D., West New York; Associate Attending in Otolaryngology, North Hudson Hospital, Weehawken

This paper is a reportorial review depicting the development of stapes surgery for otosclerosis. Starting with Kessel in 1876, Dr. Boyer will cover the work done by the leading otologists in stapes surgery at the end of the 19th century. The work of Dr. Frederick Jack and of C. J. Blake, and their results are reviewed. The opinions of others, including Politzer and Kerrison, are stated.

The paper then reports on the last decade, when Rosen first mobilized a stapes in 1952. The speaker will review chronologically the development of stapes surgery which followed, and further advanced technics of Rosen, Shea, House, Portmann, Goodhill and others. The opinions and conclusions of symposiums are also given.

Julio T. Noguera, M.D., Asbury Park; Director of Otolaryngology, Fitkin Memorial Hospital, Neptune

Multiple surgical attacks on the otosclerotic stapes were devised after Rosen stimulated the direct approach in 1955. As experience has accumulated one procedure seems to have the highest incidence of success: total stapedectomy.

The technics now used by several of the outstanding otologists are reviewed. Dr. Noguera's own approaches and the rationale behind them are reviewed. Not only is the local pathology taken into consideration on deciding which approach should be used, but also the pathologic physiology of the otosclerotic disease, as well as its anatomic features.

Complications, as reported by many operators, are discussed.

Isadore M. Schnee, M.D., Attending in Otolaryngology, Barnert Memorial Hospital, Paterson

Tympanoplasty is indicated in conducive deafness associated with middle ear infection. The aim of the operation is to eradicate pathology and restore hearing. This involves mastoid and middle ear surgery and reconstruction of a conducting mechanism. Postauricular skin has been used for the new drum. A new technic now aims additionally at preservation of normal anatomy. The middle ear surgery is done through the external canal, the mastoidectomy through endaural incision preserving the posterior canal wall, the drum defect repaired with vein graft and the ossicular chain reconstructed with polyethylene. A modification of this procedure is described.

Walter A. Petryshyn, M.D., Montclair; Assistant Professor of Clinical Otolaryngology, New York University Medical School, New York, N. Y.

With the development of stapes surgery and the tympanoplasty, the facial nerve has become again a structure of prime surgical importance. Exact anatomic knowledge of its course in the temporal bone and its microscopic relationship to other structures is essential in the new procedures.

Accidental injuries to the facial nerve occur and must be diagnosed and treated promptly to prevent tragic consequences. Surgical decompression of the nerve may be necessary in cases of Bell's palsy which do not respond to medical therapy.

11:45 a.m.

Visit to Exhibits

1:00 p.m.

Luncheon—Sections on Ophthalmology and Otolaryngology, and New Jersey Academy of Ophthalmology and Otolaryngology

Reservations: Mr. Randall Norris, 367 New Bridge Road, Bergenfield

Educational Exhibits

Exhibit Hours

1:00 p.m. - 5:00 p.m., Sunday, May 13, 1962
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 14 and 15, 1962
9:00 p.m. - 1:00 p.m., Wednesday, May 16, 1962

Booth E-101. Periodontal Diseases—The New Jersey State Dental Society, Camden

Information concerning the nature, causes, prevention and treatment of periodontal diseases.

Booth E-102. Small Plant Medical Services and Emergency Treatment Kits—Committee on Industrial Health, The Medical Society of New Jersey

Panel display of suggested plans for medical services to small industries (under 500 persons). Fourteen plastic emergency kits, each kit with complete description of emergency usage.

Booth E-103. Detection and Classification of Hearing Loss—Committee on Conservation of Hearing and Speech, The Medical Society of New Jersey

The exhibit consists of placards reviewing the more common disorders and some testing technics which could be employed in the average office.

Booth E-104. Society for Relief of Widows and Orphans of Medical Men of New Jersey—Newark

Educational, to inform physicians of the aims and advantages of this non-profit organization which is truly a helping hand Society and often puts food on a table until such time as regular insurance is paid or estate freed.

Booth E-105. Unproved Cancer Therapy—A Continuing Challenge—American Cancer Society, New Jersey Division, Inc., Newark

The exhibit highlights the extent to which unproved cancer therapy affects cancer victims throughout the nation despite the high level of scientific medicine practiced today. A series of photographs shows some of the harmful results of such therapy. The principal centers of unproved cancer therapy during the past ten years, indicated on a map of the United States, illustrate that it is a nationwide problem.

Booth E-106. Recognition and Treatment of Learning Disorders in Children—Committee on Child Health, The Medical Society of New Jersey

Early detection and differentiation of learning disorders in children with two major groups; the organic and the functional. Suggested therapy for each type.

Booth E-107. Nutrition Nonsense—Department of Foods and Nutrition, American Medical Association, Chicago

This exhibit deals with diet delusions and food fads. It also shows the value of the various groups in good nutrition. The exhibit has a built-in tape recording of house-to-house food supplement salesmen's pitches taken from actual government investigations.

Booth E-108. Academy of Medicine of New Jersey—Bloomfield

Display of data describing the functions of the Academy and its Medical Library.

Technical Exhibits

Exhibit Hours

1:00 p.m. - 5:00 p.m., Sunday, May 13, 1962
9:00 a.m. - 5:00 p.m., Monday and Tuesday, May 14 and 15, 1962
9:00 a.m. - 1:00 p.m., Wednesday, May 16, 1962

Abbott Laboratories **Booth 39**

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

American Mutual Liability Insurance Co. **Booth 13**

Risks attending elective surgery or results of such surgery are the bases of many liability claims. New and up-to-date medico-legal consent forms with legal analysis will be available for physicians.

American Mutual's *Standard Procedures for Nurses in Industry* is in a booklet containing provisions for approval or amendments by the physician. This brochure is available at booth 13. Although used primarily by the industrial physician, it can be adapted for other positions such as Public Health or School Nurse.

The Aquarest Corporation **Booth 69**

Aquarest is a large fiberglass vessel with thermostatically-controlled warming element and circulator using physiologic saline solution as a compensatory human environment for relieving disabilities related to stresses of gravity, temperature, and fluid biochemical maintenance. It is a lightweight, all-plastic, compact, low-cost, no-plumbing, mobile, fullbody hydrotherapy, hydromassage apparatus designed for hours of occupancy by patients with disabilities ranging from burns to arthritis, pregnancy fatigue to insomnia, lower-back pains to "tension."

Ayerst Laboratories, Division of American Home Products Corporation **Booth 24**

Visit the Ayerst Laboratories' Booth 24 where Grisactin®, Dermoplast® and Riopan® will be displayed. An Ayerst representative will be happy to answer your questions.

Baby Services, Inc. **Booth 57**

New Jersey's largest diaper service will be on hand for the twelfth consecutive year to show the medical profession the latest improvements in professional diaper processing. Once again we will have a beautiful Baby Service red rose for each of the ladies. We look forward to greeting old friends and new at booth 57.

The Baker Laboratories, Inc. **Booth 51**

You are invited to visit booth 51 where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

E. & W. Blanksteen Agency, Inc. **Booth 3**

Information and literature is available at booth 3 regarding The Medical Society of New Jersey's officially-approved plans of major medical and disability insurance.

The Borden Company **Booth A**

Borden's new dermatologicals, unique amino acid therapy (reported to stimulate growth of epithelial tissue) available in water-washable, antiseptic creams, Methatar®, Methaphor®, also Methaseptic® dermatologic soak. A handy, concise guide to treatment of skin disorders is available at booth A. Bremil® and Mull-Soy® are foremost among Borden's complete line of infant formulas.

Breon Laboratories, Inc. **Booth 2**

Breon will present its complete line of antiasthmatic products—Bronkometer®, Bronkospray®, Bronkophrine®, Bronkotabs® and Bronkotab® Elixir for the prophylactic and therapeutic management of bronchial asthma; Fortizyme®—a new concept in anti-inflammatory therapy; Diaparene® for prevention and treatment of diaper rash; Caroid and Bile Salts Tablets®, and Esta® products for more reliable family planning.

Bristol Laboratories, Division of Bristol Myers Company **Booth 66**

Bristol Laboratories' exhibit at booth 66 features information on a new oral penicillin, Prostaphlin®, orally effective against penicillin-G staphylococci. Now, for the first time, treatment in the office and home as well as in the hospital becomes practical and reasonable with this new special-purpose penicillin—all the anti-staphylococcal activity of Staphcillin . . . orally.

Burroughs Wellcome & Co. (U.S.A.) Inc. **Booth 26**

You are cordially invited to visit Burroughs Wellcome & Co. (U.S.A.) Inc. at booth 26. Here you will find the latest information on our products, and the newest developments from the extensive research facilities of Burroughs Wellcome & Co.

Of particular interest in 1962 is our new topical and ophthalmic antibiotic products, as well as our "Actifed-C" Expectorant®. Our informed staff wel-

comes this opportunity to show you these new products.

Cameron Instruments Company — Booth 67

At the Cameron booth (67) this year two new electro-surgical units for general surgery and urology are being demonstrated.

The first electrified biopsy forcep is also being shown together with numerous instruments for the office and clinic.

Ask to see the "daylight" rectal set and the genuine Lempert headlite.

Carnrick Laboratories, Division of G. W. Carnrick Co. — Booth 52

Carnrick Laboratories welcomes you to booth 52 which will feature Midrin® capsules, the new product which relieves migraine, migraine variants and tension headaches by reducing intracranial pressure and throbbing, emotional stress and cephalic pain; Buta-Penite® and Penite®, the more effective coronary vasodilators; Bontril®-Timed, the triple-layer, triple-release tablet that provides maximum anoretic activity at the hunger peaks; Nolamine® Tablets, Elixir and Expectorant, for rapid and more prolonged relief of nasal congestion.

Ciba Pharmaceutical Company — Booth 29

Forhistal® is a new, low-dosage anti-allergic and antipruritis agent. Clinically, Forhistal® has proved highly effective in a wide range of allergic and pruritic disorders. It is well tolerated by patients of all ages. Forhistal® is available in four forms of issue: Lontabs®, Tablets, Syrup and Pediatric Drops.

The Coca-Cola Company — Booth 47

Ice-cold Coca-Cola is served at booth 47 through the courtesy and cooperation of the Coca-Cola Bottling Company, Atlantic City and The Coca-Cola Company.

Desitin Chemical Company — Booth 34

Desitin® Ointment is used for burns, ulcers, diaper rash, and abrasions. Desitin® powder relieves chafing, sunburn and diaper rash. Desitin® suppositories and rectal ointment will relieve pain and itching in uncomplicated hemorrhoids or fissures.

Desitin® Baby Lotion is both protective and antiseptic. Desitin® Acne Cream is a non-staining, flesh-tinted "Medicream" for acne vulgaris. Also featured is our supermild Desitin® Cosmetic and Nursery Soap.

Desitin® suppositories with hydrocortisone afford prompt response to inflammatory conditions in proctitis, severe pruritis and edema. Desitin® ointment with hydrocortisone provides hydrocortisone 1 per cent (as the alcohol) added to the well-known Desitin® formula of Norwegian cod liver oil. Our hydrocortisone cream is non-staining, washable hydrophilic base with aluminum acetate solution. This is an elegant cosmetic preparation with 1 per cent hydrocortisone.

Desitin® Cor-D-Tar Cream is a non-staining, hydrophilic base with a special solution coal tar 3 per cent and non-staining diiodohydroxyquin 2 per cent. It is ideal for bacterial-fungal-infectious eczematous discomfort.

The Dietene Company — Booth 19

Have you tasted Meritene®? Meritene® is the palatable protein-vitamin-mineral food supplement prescribed to provide concentrated nutrition for patients with poor appetite or tolerance for ordinary food. Visit booth 19 and let us serve you a cool, refreshing Meritene® nourishment. Then look over our Dietene® Reducing Plan, designed to get better cooperation from overweight patients. The Dietene® plan provides optimum nutrition and maximum satiety without drugs.

Meritene® and Dietene® are advertised only to the medical profession.

Eaton Laboratories — Booth 48

The Medical Service Representatives at the Eaton booth (48) welcome the opportunity to be of service to you. Complete information is available concerning the nitrofurans. The Eaton Medical Film Library, Student AMA Photo Salon and other special services to the profession.

Thomas A. Edison Industries, McGraw-Edison Company — Booth 38

Edison Voicewriter—"Dictation Center U.S.A."—will show a complete line of business recording equipment: Edison Voicewriter® M-E models are full-featured dictating instruments for executive and secretarial use; Escort® is a battery-operated, portable dictating instrument; Envoy® is a budget-priced magnetic tape dictating-transcribing machine; Midgetape® is a unique battery-operated pocket-size tape recorder; Televoice® identifies our phone network dictating systems.

Geigy Pharmaceuticals — Booth 56

Geigy cordially invites members and guests of the Society to visit its exhibit at booth 56. This features important new developments in the management of inflammation, as well as current concepts in the control of hypertension and edema: depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

Gerber Products Company — Booth 35

New! Gerber Modilac® is a complete formula for infants. Gently processed to conserve nutritional values, it has true milk color and flavor. Modilac® is milk adapted to the infant's physiologic requirements by the addition of a selected carbohydrate, replacement of butterfat with corn oil and supplementation with needed vitamins. Ask for complete information.

Geriatric Pharmaceutical Corp. **Booth 60**

Geriatric Pharmaceutical Corporation, pioneers in geriatric research, will exhibit Ger-o-foam®, an anesthetic analgesic in aerosol form which, when massaged into muscular-skeletal conditions, will relieve pain in minutes and last for hours.

We will also exhibit Gaysal® for the management of arthritis.

Health Insurance Council **Booth B**

The Health Insurance Council serves, on behalf of the nation's insurance companies, as a central source of information and counsel to physicians, hospitals, and others in the health care field on all aspects of health insurance. The Council seeks to promote cooperation and understanding between those who provide health care and those who help finance its cost . . . to the end that the insurance business may provide the most effective and satisfactory health insurance protection possible.

Holland-Rantos Company, Inc. **Booth 62**

H-R exhibit will feature and representatives will be pleased to discuss:

Hyva® Gentian Violet Vaginal Tablets, a simple vaginal antimycotic treatment;

Improved Nylmerate® Jelly and Nylmerate® Antiseptic Solution Concentrate for trichomoniasis, leukorrheas and mixed infections;

Hollandex® skin ointment for dermal disorders—diaper rash; chafing; skin dryness; prickly heat and sunburn.

Koromex® vaginal jelly for conception control when "Jelly Alone" is advised;

Koro-Flex® Contouring Diaphragms and Sets; and

Koromex® diaphragms and sets.

International Latex Corporation **Booth 12**

International Latex is introducing the new Playtex® Nurser which duplicates many of the principles of breast feeding. Its prime features are:

1. Soft, pliable container permits air to be expelled before feeding so that baby takes in nourishing formula instead of "swallowed air" which can cause distress, crying, spitting up and colic.
2. Natural shaped and natural action nipple promotes proper sucking action.
3. The bottle is pre-sterilized and disposable.

Jackson-Mitchell Pharmaceuticals, Inc. **Booth 5**

Jackson-Mitchell Pharmaceuticals, Inc. invites you to visit booth 5 where we are displaying our well-known products, Meyenberg® Evaporated and Powdered Goat Milk as well as Hi-Pro®, our high protein, low-fat powdered cow's milk. Pause at our booth and register. Samples and literature will be sent on request.

Johnson & Johnson **Booth 72**

Johnson & Johnson will display the latest improvements in surgical dressings, as developed by the Johnson & Johnson Research Laboratories. Of special interest in Surgicel® Absorbable Hemostat, a major advance in the control of hemorrhage which does not depend upon the normal clotting mechanism. Other products, designed for your office, hospital or patient use, are also displayed. You will find well-informed representatives pleased to discuss these products or provide information on any other items made available by the world's largest manufacturer of surgical dressings and baby products.

Kessler Associates, Inc. **Booth 49**

This manufacturer of prosthetic appliances with vast experience in congenital amputee problems has compiled a display of devices for children in keeping with the orthopedic section theme.

Special prostheses and their uses will be displayed and explained by certified prosthetists. Discussion of problems relative to the rehabilitation of the amputee will be welcomed with emphasis on the child or the geriatric patient.

Knoll Pharmaceutical Company **Booth 68**

You may now prescribe fruit-flavored, taste-appealing Quadrinal suspension for asthma patients who prefer a liquid to the time-proved Quadrinal® tablet. Dilaudid® for pain that synthetic analgesics frequently fail to relieve; also for "the cough that must be controlled." Metrazol®, Vita-Metrazol® and Nico-Metrazol® elixir and tablets for the geriatric and convalescent patient, and Akineton®, the new anti-parkinsonism agent.

Lamond Products, Inc. **Booth 10**

Lamond Products, Inc., features dermatologic products exclusively; Sebana® Shampoo, a new product, is a high-foaming antiseborrheic shampoo that removes all dandruff and excess sebum from the scalp; Dermasorcin® and Dermasul® are original products, flesh-tinted, for acne and seborrhea; Bur-Zin® is Burow's emulsion (oil-in-water) for eczematous eruptions; Bur-Cort® is a topical hydrocortisone therapy; Dermastringe® is salicylic acid and resorcin tincture for skin cleansing and astringent purposes; our Bentical® shake lotion, flesh-tinted, is used for pruritic states and as a vehicle; and Sunprotectol® superior sun lotion, screening out burning rays.

Lederle Laboratories Division, American Cyanamid Company **Booth 28**

Members of The Medical Society of New Jersey and their guests will be most cordially welcomed at the Lederle booth 28. Trained personnel will be on hand to answer any questions you may have concerning our specialty products. Do come and see us.

Eli Lilly and Company **Booth 63**

You are cordially invited to visit the Lilly exhibit located in booth 63. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

J. B. Lippincott Company **Booth 54**

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

P. Lorillard Company **Booth 50**

P. Lorillard Company invites you to visit the Kent Cigarette exhibit. A big part of that story is: your taste buds will tell you why—you'll feel better about smoking with the taste of Kent.

Kent with the Micronite® filter refines away harsh flavor . . . refines away hot taste . . . makes the taste of a cigarette mild and kind. Kind-tasting to your taste buds, kind-tasting to your throat.

A table cigarette box with your signature in gold will be a pleasant souvenir of your visit to the Annual Meeting.

The S. E. Massengill Company, Inc. **Booth 1**

Best wishes to The Medical Society of New Jersey for a very successful 1962 meeting. Massengill representatives will be glad to discuss any products which interest you. Exhibited will be Trimagill® and Livitamin®. Trimagill® is a logical therapy for vaginal infections and Livitamin® is the hematinic with built-in nutritional support.

McNeil Laboratories, Inc. **Booth 14**

Members of The Medical Society of New Jersey are cordially invited to visit our booth 14, Mr. A. A. Hower in charge. Products to be featured are: Butisol Sodium® butabarbital sodium; Butizide®; Butiserpazide® and Parafon Forte®.

Mead Johnson Laboratories **Booth 64**

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially-trained representatives will be on duty to tell you about their products.

Medco Products, David Levinson, Distributor **Booth 21**

Medco Products presents its famous Medcolator®, the Medco-Sonlator® and the new Kol-Therm®. These contributions to physical medicine offer the latest methods for the relief of pain and restoration of function, together with the diagnostic and therapeutic qualities presented in the Medco-Sonlator®. We welcome the opportunity to demonstrate these useful therapies at our booth.

Medical-Surgical Plan of New Jersey **Booth 15**

This year the Plan is observing the 20th Anniversary of its founding by The Medical Society of New Jersey. The Plan's exhibit highlights the contributions made over the years by its Participating Physicians, which have made possible ever-increasing service to the community. All Society members are cordially invited to visit the Blue Shield booth and receive a 20th Anniversary souvenir.

Merck Sharp & Dohme, Division of Merck & Co., Inc. **Booth 33**

The theme of the Merck Sharp & Dohme exhibit is "Service to Medicine." One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession, and also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

The Wm. S. Merrell Company **Booth 71**

Merrellmen always have an up-to-date status report on Merrell's significant prescription products. They will be happy to convey latest clinical reports to you in summary form when you visit the Merrell booth.

Milex of New York **Booth 17**

Gynecologic products will be featured at booth 17. Trimo-San® for trichomonas, monilia and mixed leukorrheas will be introduced. Amino-Cery-Creme® will be demonstrated as the treatment of choice for cervicitis and post-surgical surgery. Samples of "What The Teenager Wants To Know," "A Doctor Discusses Menopause," "A Doctor's Marital Guide" and a "Rhythm Calculator" will be available upon request. New developments in the Milex Cancer Detection Program will be surveyed. Please stop in and say "Hello."

Organon, Incorporated **Booth 25**

You are cordially invited to visit our exhibit at booth 25. Of particular interest: Durabolin®—a safe, potent, long-acting anabolic stimulant indicated in a broad range of clinical conditions where tissue building is desired. Our professional service representatives welcome the opportunity to answer your questions concerning Durabolin® or any of our other products. Best wishes for a most enjoyable visit to Atlantic City.

Ortho Pharmaceutical Corporation **Booth 55**

On display at booth 55 is a complete line of products for the control of conception. Of special interest is Delfen Vaginal Cream®, the most spermicidal contraceptive.

There is also available new data on Actase Fibrinolysin® (Human) in a new potency, facilitating the lysis of intravenous clots in an extended therapeutic range.

Representatives will welcome the opportunity to discuss these and our other well-known products with you.

Pfizer Laboratories **Booth 36**

Professional Service Representatives from Pfizer Laboratories will be pleased to have you in attendance at their booth to discuss the latest products of Pfizer Research.

Physicians' Security Incorporated **Booth 6**

Physicians' Security Incorporated offers physicians the opportunity to buy life insurance with no premium payments for the first five years. This is done through a series of notes at 6 per cent simple interest. The corporation is also making available to physicians a ninety-four page booklet entitled "Professional-Partnership Purchase Plans." This up-to-date book covers professional partnership buy and sell agreements and covers evaluation problems, tax considerations, and the various types of purchase agreements.

A. H. Robins, Company, Inc. **Booth 32**

When too much food causes your patient's complaint, prescribe Ambar Extentabs® (No. 1 or No. 2) to curb appetite without jitters. When too much water is his problem, prescribe the unsurpassed diuretic, Naclex®. It gets water out fast!

Also featured: Dimetane Extentabs®—just one provides antihistaminic relief for 10 to 12 hours. Donnazyme®—combines Donnatal® and Entozyme® for "nervous indigestion."

Roche Laboratories, Division of Hoffmann-LaRoche, Inc. **Booth 53**

Librium®—a therapeutic agent for superior, safer, faster control of nervousness, anxiety, tension and other common emotional disturbances without the dulling effect or depressant action of the tranquilizers.

J. B. Roerig and Company **Booth 37**

J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

William H. Rorer, Inc. **Booth 70**

Ananase Tablets®—a new oral, fibrin-depolymerizing (proteolytic) enzyme from vegtable origin.

Maalox®—a pleasant-tasting, non-constipating antacid in Suspension, Tablets No. 1 and Tablets No. 2.

Representatives will gladly answer questions concerning Rorer products.

Sandoz Pharmaceuticals **Booth 58**

Sandoz Pharmaceuticals cordially invites you to visit our display at booth 58, where we are featuring Mellaril®, Torecan®, Cafergot PB® and a new product, Sansert®.

Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company **Booth 40**

New Saunders titles of special clinical interest include: Current Thearpy 1962; Lore: An Atlas of Head and Neck Surgery; Williams: Endocrinology; Green and Richmond: Pediatric Diagnosis; O'Donoghue: Athletic Injuries; Fontana and Edwards: Congenital Cardiac Disease.

Schering Corporation **Booth 18**

You are cordially invited to visit the Schering technical exhibit where the following products will be featured: Celestone®, most active corticosteroid available; Fulvicin® and Advicin®, the first combination to meet the requirements for successful athlete's foot therapy; and Chlor-Trimeton®, unsurpassed antihistamine.

G. D. Searle & Co. **Booth 44**

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Smith Kline & French Laboratories **Booth 22**

Our representatives welcome the opportunity to discuss SK&F products with you and are always ready to be of help in any way they can. Products featured are: (1) Parnate® Tablets; (2) Eskatrol® Spansule® capsules®; (3) Ornade® Spansule® capsules; and (4) Tuss-Ornade® Spansule® capsules.

South Jersey Surgical Supply Company **Booth 27**

This year, South Jersey Surgical will introduce for the first time the brand new Hamilton Examination Room Suite, priced at only one-half of what you would expect to pay. In addition to this there will be an exhibit of the very latest in physical therapy and EKG equipment.

E. R. Squibb & Sons **Booth 65**

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed.

At booth 65, we are pleased to present up-to-date information on these advances for your consideration.

William Allen Steadman & Company **Booth 11**

William Allen Steadman & Company are the originators of complete financial service to the medical profession.

This company is the investment adviser and the underwriter for Steadman Investment Fund, Inc.

It is also the underwriter for Professional Service, Inc. These companies were organized at the request of a group of New Jersey physicians in

order to provide financial and investment assistance from internship through retirement.

Physicians and their wives are cordially invited to visit the booth.

U. S. Vitamin and Pharmaceutical Corporation — Booth 43

DBI®—new "broad-range" oral hypoglycemic agent. DBI®, brand of phenformin (N^1-B-phenethylbiguanide HCl), is distinctly different in chemical structure and physiologic action from the oral hypoglycemic sulfonylureas. It effectively lowers blood sugar and eliminates glycosuria in mild, moderate and severe diabetes. DBI®, in combination with insulin, improves regulation of "brittle" adult and juvenile diabetes. In juvenile diabetes, DBI® often permits up to 50 per cent reduction in insulin requirement. Also effective in the insulin-resistant, and in primary and secondary tolbutamide and chlorpropamide failures. Full details available.

The Upjohn Company — Booth 31

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

W. T. S. Pharmaceuticals, Division of Wallace & Tiernan, Inc. — Booth 59

Desenex®: Most widely prescribed fungicide used in the prevention and treatment of athlete's foot and other superficial fungous infections of the skin.

Caldesene®: Provides a lubricating and emollient film which is effective in the prevention or treatment of diaper rash and minor skin irritations.

Walker-Gordon Laboratory Company — Booth 46

You are invited to taste-test Walker-Gordon Certified milks at booth 46. You will find there the new Certified Lo-Sodium Milk, which has been especially processed to reduce its sodium content from around 500 to less than 50 milligrams per quart. Walker-Gordon 900®, a 900-calorie food for weight control, Acidophilus Milk, Certified Pasteurized Milk and Certified Skimmed Milk will also be available.

The Walker-Gordon Laboratory Company's Certified Milk Farm in Plainsboro, New Jersey, is the world's largest farm producing Certified Milk. It includes over 2,400 acres of farm land and 2,690 cows and growing heifers.

It is the home of the famous Rotolactor, the purpose of which is to make possible the production of the highest quality milk.

Walker-Gordon Certified Milk is distributed in the metropolitan areas of New York and Philadelphia and in the State of New Jersey by many leading milk dealers.

Wallace Laboratories, Division of Carter Products Inc. — Booth 16

Wallace Laboratories' exhibit is on Soma Compound®, a new analgesic for the relief of pain, tension and fever in neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions and other conditions in which pain, tension and fever are symptoms. It contains Soma®, a new type of analgesic which has proved highly effective in relieving both pain and tension; phenacetin, and caffeine. For relief of more severe cases, Soma Compound® with Codeine adds to the ¼ grain of codiene phosphate. Since Soma Compound® potentiates the effectiveness of codeine, only ¼ grain is required to relieve the more severe pain which usually requires ½ grain.

Warner-Chilcott Laboratories — Booth 23

Gelusil®—the physician's antacid—for lasting relief of pain and control of gastric acid by neutralization and adsorption. The unique dual gel formed by Gelusil® protectively coats irritated and eroded mucosa. Gelusil® is inherently nonconstipating—contains no laxative.

Peritrate®—for the patient with coronary artery disease—with or without angina. Peritrate® increases myocardial blood flow and oxygen supply safely—with no significant change in blood pressure, cardiac output or pulse rate.

The Warren-Teed Products Company — Booth 30

The Warren-Teed Products Company will feature four specialty products at their exhibit booth 30.

Modane® Tablets—A deconstipant for relief and rehabilitation of the atonic bowel.

Ilopan®—An injectable d-pantothenyl alcohol for the treatment and prevention of flatulent gastrointestinal distention.

Ilomel® Powder—Anti-ulcerogenic plus classic antacid management of peptic ulcerations.

Ilocalm® Tablets—Anti-ulcerogenic plus classic anticholinergic management of peptic ulceration.

Warren-Teed representatives cordially welcome all registrants to visit their display.

Westwood Pharmaceuticals, Division of Foster-Milburn Co. — Booth 45

Westwood invites physicians to stop by their booth to discuss their unique dermatologic products:

Fostex® Cream; Fostex® Cake; Lowila® Cake; Lowila® Emollient; Sebulex®; Alpha-Keri® and Fostril.®

These products are particularly suitable for personal use by physicians and their families who may be plagued with dandruff, acne, dry and itchy skin, and sensitivities to soap. Register, so that we may send prescription units to your home.

White Laboratories, Inc. — Booth 41

White Laboratories' exhibit features Permitil Chronotab® Tablets which provide uninterrupted day-long control of anxiety symptoms, Sorboquel® Tablets which provide dual control of the dual problem in acute and chronic diarrhea (too fluid feces, too frequent evacuations) and Sorboquel® with Neomycin® Tablets for prompt control of acute bacterial diarrheas. Also featured will be Disomer®, an antihistamine which exhibits a higher level of therapeutic effectiveness with minimal side-effects.

Bergen

WALTER WAHRENBERGER, M. D., President, Englewood

The administrative year of the Bergen County Medical Society, in keeping with the current emphasis in medical affairs, was dominated by legislative matters. One can scarcely fail to reflect on the complexity that has fallen upon the personal and delicate relationship of physician to patient that characterized medical practice in yesteryear.

As always, membership has been no problem in Bergen, since we have seen it double in a dozen or so years. Since last September the Membership Committee has processed 86 applications of all types.

Recognizing that poor member participation in medical society affairs has restricted our successful performance, the year was started with an appeal for active interest and support in society affairs. A new approach to programming meetings was adopted. Subjects for presentation were limited to socio-economics of medicine as follows:

1961

September—Installation Dinner Meeting

October—"The Declining Role of the Physician and What We Can Do About It"—Henry Heimlich, M.D.; "Threats in Our Society to the Freedom of the Professions"—Mr. Edmund A. Opitz

November—Joint Dinner Meeting with Bergen County Bar Association

December—"The Professional Corporation" —Mr. Martin Holbrook; "X-ray Your Estate Body Before Prescribing Treatment"—Mr. Chester L. Chambers

1962

January—Debate on "Medical Care for the Aged under Social Security"—Mr. James Hallet, Travelers Insurance Co.; Mr. Joel Jacobsen, AFL-CIO.

February—Panel discussion on "Rising Hospital Costs"

March—"Comments and Observations on Pending Legislation"—The Honorable Richard J. Hughes

April—"The Doctors Organizations and Role in Medical Legislation"—Edward R. Annis, M.D.

May—Annual Business Meeting

June—"The Administration Plan for Medical Care of the Aged"—Mr. Wilbur J. Cohen, Assistant Secretary, Department of Health, Education and Welfare

It is felt that this new approach and the interesting subjects and speakers were largely responsible for the improved attendance. Executive Committee meetings were prolonged and productive and carried the burden of routine business affairs of the Society. Our budget attained an all-time high with the addition of $4500 to the Bergen County Medical Society's scholarship fund.

Community Service is joining with the Health and Welfare Council of Bergen County in co-sponsoring a health show for county residents in May.

Judicial Committee met monthly, rendering decisions on 30 complaints.

Three representative members and the executive secretary joined in the Trenton legislative roundup held in January.

The newly-organized Medical Review and Advisory Committee considered seven cases. Only one instance of litigation has occurred since the committee's inception.

The Committee for School and Child Health has continued to champion the concept of school physical examinations by family physicians despite stubborn opposition from state agencies.

An active liaison between high school coaches and our Athletic Injury Prevention Committee is gradually molding safer standards for student safety. Many programs are still being pursued.

In furtherance of a basis for understanding between the Bar and Medicine as initiated with the first Bar Liaison dinner meeting, respective committees of the two groups are meeting to bring mutual understanding to members.

Our Speakers' Bureau, since last April, has addressed 33 lay groups on various medical subjects. Additionally, a course of ten lectures for an adult education program was prepared and delivered by ten different members.

With the addition of two loans made during the past few months, we have now six students in medical school being financially assisted through our own county medical scholarship fund.

A concerted effort to lend more active support to Visiting Homemakers, both through financial support and provision of volunteer workers, was initiated and will be hopefully pursued.

An Orientation Committee for new members was organized and is to begin functioning this spring.

A Committee for Future Physicians Clubs has been organized and is preparing to initiate a pilot program in one or two schools.

The approval of professional association with osteopaths was expected to bring forth a rash of problems. Save for some rumors of osteopaths' applying for scattered hospital privileges, there has been no open conflict and no grounds for misunderstanding. No overtures for liaison between osteopathy and medicine have taken place.

Emergency Medical Service has continued to function effectively. A monthly average of 34 calls was received and promptly dealt with.

Thanks are again extended to our distaff side, the Woman's Auxiliary. Through subscription affairs the ladies have made substantial additions to the county medical scholarship fund and toward nurses scholarships, both of which were originated by them.

In the handling of newspaper releases and queries and in writing the monthly president's page, a sincere and distinct attempt to represent the majority attitude of the membership and to fortify the stands of the AMA has been made.

Camden

William T. Read, Jr., M.D., President, Camden

During the year 1961-62 the Camden County Medical Society accomplished several important items of business.

Under Dr. James R. Herron, Chairman of the Membership Committee, the Indoctrination Kits were assembled for new members. We discussed a special telephone listing of the Camden County Medical Society membership. This was investigated thoroughly and several complicating features were found, particularly that the telephone listing covers more than the Camden County area. The subject was distinctly controversial, and through a mail vote the telephone listing was not approved by the membership.

The Woman's Auxiliary to the Camden County Medical Society has been very successful in its annual Health Education Day. For this important work, the Society voted an appropriation to the Auxiliary for 1962.

Due to the increased work of the executive secretary, a full-time assistant was obtained in the Summer of 1961. In addition, all work of the Society—both that of the Treasurer and the Secretary—was transferred to the Executive Offices.

A Budget Committee was formed this year under the Treasurer, Dr. Louis G. McAfoos, Jr. and a budget presented to the Society for its approval.

The Public Relations Committee under Dr. Elmer L. Grimes, chairman, established a Future Physician's Club for high school students. Sixty students from six local high schools visted two medical schools in Philadelphia and two Camden County hospitals for observation of medicine in action.

It has also been agreed by the Executive Committee that the scientific papers given at three of the meetings of the general society be open to the press.

The programs this year obtained by Dr. Robert L. Breckenridge, chairman of the Committee, were as follows:

October: Dr. Charles S. Petty, Assistant Medical Examiner, State of Maryland—"The Definitive Investigation of Death"

January: Captain F. K. Smith, Director, Aviation Medicine at Naval Air Development Center at Johnsville, Pa.—"Aerospace Medicine"

March: Dr. Paul Fremont-Smith, Peter Bent Brigham Hospital—"Current Concepts of Antibiotic Therapy"

Essex

Robert H. Areson, M.D., President, Upper Montclair

The big issue during this current legislative year was "Should Old Age Medical Care be Financed through Social Security?" Dr. Edward R. Annis, Chairman of the AMA Speakers' Bureau, spoke on this at an open forum on April 8, 1962 at 8 p.m. in Newark. The Essex, Hudson, and Union County Medical Societies, as well as the New Jersey Chamber of Commerce, co-sponsored this well-attended meeting.

The Essex County Medical Society reaffirmed the State Society position of December 1947 "that the sending of ambulatory private patients to hospitals for x-rays, laboratory examinations, and physical therapy treatment be discouraged where adequate facilities are available in private physicians' offices." We have also set up a committee to maintain and further the concept of private practice within our county.

More than 2,000 finger blood tests were administered to Essex County residents at our two diabetes testing stations last November. We used Clinitron machines, and the "positives" were reported to their family physicians. This public testing program was highly successful due to the wonderful cooperation shown by such groups as the Newark and East Orange Departments of Health and the State Department of Health.

To cooperate more fully with the local press, we supplied medical reports with a list of physicians in each of the specialties. We have asked these physicians to answer such questions as the reporters may ask. We asked the reporter to use the doctor's name only if necessary, and then to quote him as chairman of the Scientific Committee of the Essex County Medical Society. Reporters have found this helpful in checking the scientific worth of the many press releases that come to their attention.

Our Future Physicians Club program was given official approval by the AMA at the June 1961 meeting of the House of Delegates. Since then we have had excellent coverage in *Medical Economics*, *World Medical News*, national school publications, science digests, and many other newspapers and periodicals. We have received a better press on this project than on any other project our Society has undertaken in recent years. Our 42 high school Future Physicians Clubs are very active and under the direction of Dr. S. William Kalb, who originated this idea. Over 200 other medical societies have written to us during the past year requesting information on how to start a Future Physicians Club in their area.

Our Society, together with the Inter-Professional Health Council of Essex County, will sponsor an Essex County Health Fair June 5 to 9, 1962, in West Orange. Over 100 agencies have already signed contracts to have an exhibit at this fair. The AMA is lending us their "Transparent Twins," two life-sized figures of clear plastic in which will be demonstrated the functions of the body. We will have a telephone exhibit, at which the public will be able to pick up a phone and listen to a recording which tells of the many public services rendered by our Society.

Our Speakers' Bureau sent out over 250 speakers to the public during the year. They have given medical talks to almost every type of organization. Our members gave courses to graduate nurses, medical assistants, and set up programs at evening adult schools. We give our speakers plaques for performing this public education service.

A special committee of our Society is currently investigating an Association Pension Plan for our members. This would permit members who desire to make monthly payments to place half of the monthly payment into a straight life policy and half into a Mutual Fund. It has just been cleared by the S.E.C. and the Banking Commission, and we hope to learn more about its pros and cons before making a decision.

Another type of group insurance has been offered to our membership during the year. This new policy, Major Medical, has had an excellent reception from our members, and we need only a few more applications to qualify as a group. Our Loss Control Committee came into being last Summer and has held many meetings since. This medical review and advisory committee seems to be working very effectively with our new professional liability carrier.

Our Executive Secretary, Mr. Arthur Ellenberger, has been extremely helpful in implementing our programs and securing good public relations for our Society.

Gloucester

Rudolph T. DePersia, M.D., President, Paulsboro

On May 18, 1961, Dr. Grasteen, Emeritus Professor of Psychiatry at the University of Pennsylvania, spoke on "People in Distress, in Quandries, and in Flight" with recorded interviews. He emphasized prevention and various treatments.

The following officers were elected: Drs. Rudolph T. DePersia, President; Francis M. Brower, Vice-President; George R. Booth, Treasurer; Richard P. Gotchel, Secretary; Dorothy M. Rogers, Historian and Reporter. Our own Dr. Collins was elected as a State Society Trustee and Dr. Patterson as a delegate to the AMA.

At the September meeting, we had an interesting panel discussion of low back pain by Drs. John Gartland, orthopedic surgeon; Richard Robit, neurosurgeon; Jules Bogaev, urologist; and Walter Hussong, a psychiatrist.

The Annual Social Session, held October 19, 1961, was attended by 108 members and guests. Dr. Franz Polgar was the main speaker, whose subject was "Miracles of the Mind."

At the November meeting, Mr. Vincent A. Brown, representative from Medical-Surgical Plan of New Jersey, presented several contract changes recently in effect. Reports by Drs. Guy Campo, legislative chairman, and Isaac N. Patterson, brought members up to date on recent considerations of state and AMA matters. Local hospitals cooperated in the success of Diabetic Detection Week.

Drs. Ian M. Goonewardene and Rita Mariotti were elected as associate members. Dr. John A. Sturgis was welcomed as an active member. Dr. Gaston M. Trigos of Philadelphia Medical Society was elected to courtesy membership. Four others applied for associate membership. Dr. Jacqueline Coant applied for transfer membership; and Dr. William Lemmon, for courtesy membership. Dr. Wendell Burkett sent a letter of resignation, which was accepted with regret after his long membership in our Society.

In December, we had a joint meeting with the Gloucester County Dental Society. Dr. Arthur W. vonDeilen, discussed "Maxillo-facial Injuries," emphasizing the need for arrest of hemorrhage, maintaining airway, controlling shock early as well as aiming toward cosmetic satisfaction secondarily.

Hunterdon

Arno W. Macholdt, M.D., President, High Bridge

After several months of committee work, a tetanus prophylaxis schedule was adopted by both the Hunterdon County Medical Society and the staff of the Hunterdon Medical Center. This schedule stresses the use of tetanus toxoid and antibiotics for tetanus prophylaxis. It has worked well in Hunterdon County, and the incidence of reactions to tetanus antitoxin has been drastically reduced.

Regulations were also adopted for the organization and administration of the Poison Control Center at the Hunterdon Medical Center. Booklets were distributed to the rescue squads in the county as well as to other qualified persons and organizations.

This Society co-sponsored a series of premarital classes for young people. The classes will be given by clergymen and members of the departments of Obstetrics and Psychiatry of the Hunterdon Medical Center, with representation from the general practitioners.

One of the interesting programs was the presentation of the Smith Kline and French-sponsored film on "Closed Cardiac Massage."

Salem

William L. Sprout, M.D., President, Salem

The Salem County Medical Society began 1961 by urging our Board of Freeholders to create the position of county health officer or health coordinator. This effort is finally beginning to win support in 1962 in the form of editorial comment in the local press.

One internist volunteered to serve on the panel to review results of examinations on suspected cardiacs when requested by the New Jersey Division of Motor Vehicles. Since I am also a member of the Special Committee on Traffic Safety, I am especially eager to see this program intelligently implemented.

Two important standing committees were added to our roster this year: a Medical Review and Advisory Committee was established, to cooperate with the American Mutual Liability Insurance Company's Loss Control Program; and a Radiation Problems Committee was appointed, consisting of a radiologist, a pathologist, a surgeon and the physcian stationed at the Philadelphia Air Defense Site at Pedricktown. The radiologist, as chairman, was authorized to speak to the public and press as the Society's official spokesman on radiologic defense. His availability should help to allay anxiety and forestall ill-advised actions, such as the unnecessary avoidance of milk because of fear of strontium-90 contamination. The Woman's Auxiliary received permission to cooperate with local civil defense authorities.

This year the president and the legislative committee have exerted their best efforts in "Operation Contact" to induce other Society members and their non-medical friends to write to their Congressional representatives opposing the Kennedy-Ribicoff plan for health care for the aged. I was disappointed to observe that my letter to Senator Case received a reply which varied in only six words from that Senator's reply to correspondence in February 1961 concerning the Kerr-Mills Bill. Senator Williams also replied that he was still in favor of the Social Security approach and enclosed a copy of the speech he had made on April 6, 1960—two years ago! Apparently our current efforts are largely being wasted, since these officials appear content to stand on their positions of one and two years ago.

Somerset

Jon M. Wilson, M.D., President, Bound Brook

"Emphasis on Education" keynoted the 1961-62 program of the Somerset County Medical Society. The Society's efforts have been aimed at physicians as well as laymen.

Quarterly meetings of the Society have been held in conjunction with the regular monthly educational programs of the medical staff of Somerset Hospital. These programs proved to be mutually advantageous and well attended. They featured guest lectures by outstanding medical men in fields of interest to the house staff, medical staff, and medical society.

Held on Thursdays at 4:30 p.m., the lectures are followed at 6 p.m. by an excellent buffet supper in the hospital dining room. All physicians are invited to attend. Cost of the buffet is defrayed, in part, by a contribution from the Society. At 7 p.m., the Society conducts its business meeting, which ends with a guest speaker or film.

During the past year the Society sponsored two courses in the Bound Brook Adult School. The first, "Medicine and the Layman," consisted of ten lectures given by Society members. This was extremely popular and well attended. An honorarium given to the Society for its sponsorship was donated to the Medical Student Loan Fund of The Medical Society of New Jersey.

The second course, "The Medical Secretary and Receptionist," now is in progress. More than 50 people are enrolled. Lecturers include physicians, a receptionist, a pharmaceutical salesman, a lawyer, and a representative of the telephone company.

Both courses have proved to be excellent public relations instruments for the Society.

Union

Henry J. Konzelmann, M.D., President, Hillside

The membership of the Society is steadily growing: 558 active members, 38 associates, 16 emeritus, 5 residents, and one honorary member. Last year 9 members died; among them, Dr. Rowland P. Blythe, who was President of the Society in 1939.

The indoctrination Program had two very successful meetings. At the fall meeting we were pleased to have observers from the Bergen County Medical Society.

The President attended several meetings of the Union County Traffic Council which have been of mutual benefit. Through this activity, questions regarding physicians' services in accident cases and our emergency medical service have been clarified.

Since the mobile unit of the Red Cross came into the area and the Central Blood Bank was established, blood problems have greatly decreased.

The Emergency Medical Service Committee has found this past year less pressing problems, but one which still needs a great deal of work is the education of the general public on the proper use of the service. The new cards distributed to the schools, police departments, Welcome Wagon hostesses, health and welfare agencies giving detailed instructions on the proper use of the service will, we think, stop some of the unnecessary non-emergency calls.

The Judicial Committee has held meetings which have proved beneficial to both doctors and patients. Also very busy is our Membership Committee, and with the ever-increasing number of applications received, a great deal of time is spent in screening them. All applications are carefully checked and all material necessary is prepared before the meetings to help facilitate the work of the committee.

The Program Committee provided outstanding speakers on a wide range of subjects. Mr. Henry F. Hoey, Jr., attorney for the American Mutual Liability Insurance Company, spoke on professional liability insurance; Mr. E. H. Lautenschlager, of the U. S. Treasury, reviewed "Selection of Returns for Audit"; Mr. B. N. Sheff, of the Department of Labor and Industry, talked on "Temporary Disability Insurance"; and Dr. Jesse McCall, President of The Medical Society of New Jersey, with Mr. Nevin, Executive Officer, gave a most informative talk on the affairs of the State Society at our annual meeting.

The Diabetic Committee gave a fine educational program during Diabetic Week and have continued the program throughout the year.

The Advisory Committee to the Visiting Nurse Association of Eastern Union County held several meetings with commendable results. The VNA has just moved into a new building, which gives much needed space to carry out the increased programs with patients and physicians.

The Advisory Committee to the Union County Tuberculosis and Health Leagne has held informative meetings, particularly in regard to the new clinic, which has been set up at one of the Elizabeth hospitals with a medical director and staff to carry out the new enlarged program.

The Advisory Committee to the Woman's Auxiliary has been most helpful. One of the reasons for the increase in new members is due to the fine work of the Membership Committee, who called on the wives as soon as the doctors were elected members of our Society. The number of new members of the Auxiliary is almost the same as the number of new members in the County Society!

Dr. Jack Karel, as Chairman of the Civil Defense Committee and Medical Co-ordinator for Union County Civil Defense, has been very active with county, state, and national civil defense work. Due to Dr. Karel's deep interest, the program has taken on major proportions these past few years.

The Outing was held at the Spring Lake Country Club last fall and was hugely successful.

The Public Relations Committee has, through the cooperation of the county newspapers, kept the general public informed on medical matters and provided speakers to many lay groups.

Members of the Committees spent much time and cooperated to the fullest on every call. It is gratifying to see the interest displayed by new members in the work of the Society and of their participation in its activities.

The executive staff is busier each year taking care of the routine work of the Society with the ever-increasing number of calls from the general public for services. The growth of the towns creates some health problems, and

we are pleased to be of assistance. Because of the close working relationship with the many health and welfare agencies and executive secretaries in nearby county medical societies, we have been able to render service to those patients and physicians who need assistance. The County Society is working closely with a large county committee compiling a directory, not only on local services but those available in nearby areas for the residents of Union County.

We are naturally proud that the President-elect of The Medical Society of New Jersey, Dr. Louis S. Wegryn, is one of our members. Dr. Wegryn was president of the Union County Medical Society during 1951 and 1952 and has been dynamically active in the Society for many years.

35th Annual Meeting
Woman's Auxiliary
to The Medical Society of New Jersey

CHALFONTE-HADDON HALL

May 12 - 15, 1962

Mrs. David B. Allman, Chairman

Mrs. Harry Subin, Co-Chairman

Daily Schedule

Saturday, May 12, 1962

10:00 a.m.—Registration Opens

Tickets on sale for:

Monday—Annual Luncheon
(All doctors' wives invited)

Tuesday—Inaugural Luncheon

Sale of Dinner-Dance Tickets

3:30 p.m.—Golden Merit Award Ceremony

Sunday, May 13, 1962

10:00 a.m.—Registration

Tickets on sale for:

Monday—Annual Luncheon
(All doctors' wives invited)

Tuesday—Inaugural Luncheon

Sale of Dinner-Dance Tickets

12:30 p.m.—Pre-Convention Executive Board Meeting

2:30 p.m.—Fashion Show by Needlecraft of the Boardwalk, Tea

7:00 p.m.—Fellowettes' Dinner (by invitation)

9:00 p.m.—Medical Society Presidential Reception

10:00 p.m.—Dancing

Monday, May 14, 1962

8:30 a.m.—Registration

8:30 a.m. - 9:00 a.m.—Coffee and sweet rolls will be served

9:15 a.m.—General Session

12:30 p.m.—Annual Luncheon

2:30 p.m.—General Session Reconvenes

7:00 p.m.—Dinner-Dance

Tuesday, May 15, 1962

9:00 a.m.—Registration

Tickets on sale for:

Tuesday—Inaugural Luncheon

9:15 a.m.—Coffee and sweet rolls will be served

10:00 a.m.—Post-Convention Board Meeting

12:30 p.m.—Inaugural Luncheon

9:00 p.m.—Dancing

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

APRIL, 1962 • VOL. XXXV, NO. 4

ERADICATION OF TUBERCULOSIS IN CHILDREN

Pediatricians must be aware of the danger of tuberculosis in children and use chemotherapy and the tuberculin test as their principal tools in the campaign to wipe out this disease.

A group of authorities in various fields of medicine met at Arden House in Harriman, N. Y., in November, 1959, at the joint invitation of the United States Public Health Service and the National Tuberculosis Association. The conferees agreed that the elimination of tuberculosis as a public health problem was a practical goal but recognized that this objective was not achievable for the country as a whole within the immediate future.

Therefore, recommendation was made for the establishment of intermediate goals. Two such goals have been proposed—an active case rate by 1970 of not more than 10 per 100,000 population (the case rate in 1950 was 80), and control of infection in each community to the point where not more than 1 per cent of the children at age 14 react to tuberculin. For children, the objective is for tuberculosis to become as uncommon as diphtheria or smallpox.

CHEMOTHERAPY THE FIRST TOOL

The most important tool to attain this objective is chemotherapy. The public health reason for treating adults is to render them noninfectious. In children the suppression of contagion is not of public health interest. Even where there is marked roentgenographic evidence of primary tuberculosis, a very small population of bacilli is usually found in cultures from gastric lavage of children. Furthermore, most children with primary tuberculosis are free from symptoms, including cough. Isolation may not, therefore, be necessary, and some health departments permit a child with primary pulmonary tuberculosis to attend school if he is free from symptoms.

However, when possible, a child with newly discovered primary pulmonary tuberculosis should be admitted to a hospital for one or two days to obtain cultures from gastric lavage or from bronchial secretions. As the rate of tuberculosis falls, this procedure will become more important to identify bacilli resistant to the usual drugs. Prolonged hospitalization of children may be traumatic.

The main purpose of administering isoniazid to children with primary tuberculosis is to *prevent* complications.

Isoniazid is the only antimicrobial agent which prevents the development of complications. It is inexpensive and easily administered and should be given for at least one year in doses of 10 to 15 milligrams per kilogram of body weight.

The present trend in most parts of the world is to use combined therapy, that is, para-aminosalicylic acid (PAS) with isoniazid. In uncomplicated primary tuberculosis, and for use in secondary prophylaxis to prevent complications, there seems to be no reason why isoniazid should not be given alone.

Recent converters, very young children with reactions to tuberculin, all children with roent-

EDITH M. LINCOLN, *M.D., Archives of Environmental Health*, October, 1961.

genographic evidence of manifest primary tuberculosis, and children with complications of primary tuberculosis or with chronic pulmonary tuberculosis should be given specific therapy.

TUBERCULIN TEST THE SECOND TOOL

The second and most important tool for eradication of tuberculosis in children is the tuberculin test. The emphasis should be on the *number* of tuberculin tests and, in children with previously negative tests, on the frequency of their repetition.

The tuberculin test is extremely valuable in diagnosis but it is not infallible. A Mantoux test will produce a skin reaction when tuberculous infection is present, provided the testing material is fresh, the test is properly administered and read, and the individual tested is not moribund, convalescent from measles, or receiving steroid therapy. However, some skin reaction to tuberculin may occur in those who have never been infected with tubercle bacilli. Sometimes such reactions can be recognized as atypical. A Mantoux which is red but not indurated is not called positive. Measurement of the Mantoux is important. Less than 5 mm. in diameter is definitely negative and 10 mm. or more positive. Between 5 and 10 mm. there is indecision and the test should be repeated with the same or a slightly larger dose. A test with 5 TU of PPD (the intermediate strength) should select 99 per cent of positive reactors.

Another tool for the eradication of tuberculosis is roentgenography. In children this tool should *never* be used for surveys, but every child with a positive tuberculin test should have a roentgenogram. If the child has obvious tuberculosis, sufficient films should be taken to guide the physician in the care of the patient.

Other approaches to the prevention of infection in children, aside from treatment and segregation of infectious adults, are attempts to alter the resistance of uninfected children by vaccination or the use of isoniazid as primary prophylaxis. There is no doubt that increased resistance to exogenous infection can be obtained by vaccination, the BCG strain of attenuated bovine bacilli being the agent commonly used. This is of value in countries with a high incidence of tuberculosis, especially when given to newborn children. From a public health point of view, the artificial sensitivity produced by BCG interferes with the use of the tuberculin test in case finding. In areas of low morbidity this is a strong argument against the use of BCG.

ROLE OF PEDIATRICIAN

The prevention of tuberculous infection by the administration of isoniazid has been proved in experimental animals. The data from the prophylaxis study of the Public Health Service, when published, should show whether or not this method of prevention can be applied to human beings.

There are many contributions which the pediatrician can make to a tuberculosis control program. First, the negativism about tuberculosis must be overcome. Obviously, with a decreasing rate of infection there will be less tuberculosis and fewer tuberculin conversions. But the pediatrician must continue to be aware of the possibility of tuberculosis. Where there are tuberculous adults there are infected children. All children must be tested repeatedly in infancy and at least once a year ad infinitum or until conversion occurs; prompt treatment with isoniazid should follow conversions.

Tuberculosis is preeminently a social disease. It increases where living conditions are poor and homes overcrowded. Any measures to relieve poverty and its attendant evils of inadequate nutrition and crowding will help in the basic control of the disease. The pediatrician must function not only as a physician but also as a public-minded citizen intent on securing for every child the right to be protected from a preventable communicable disease.

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1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.; Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

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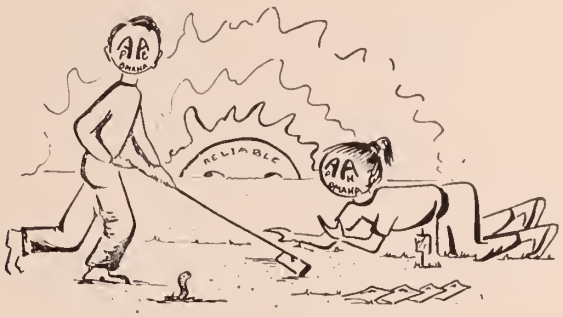
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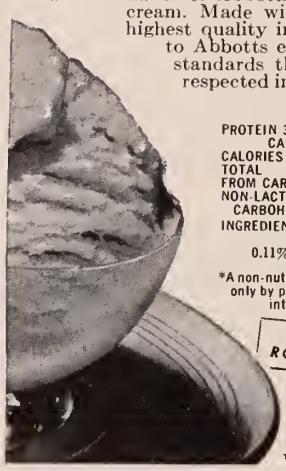
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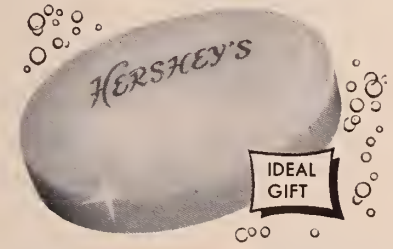
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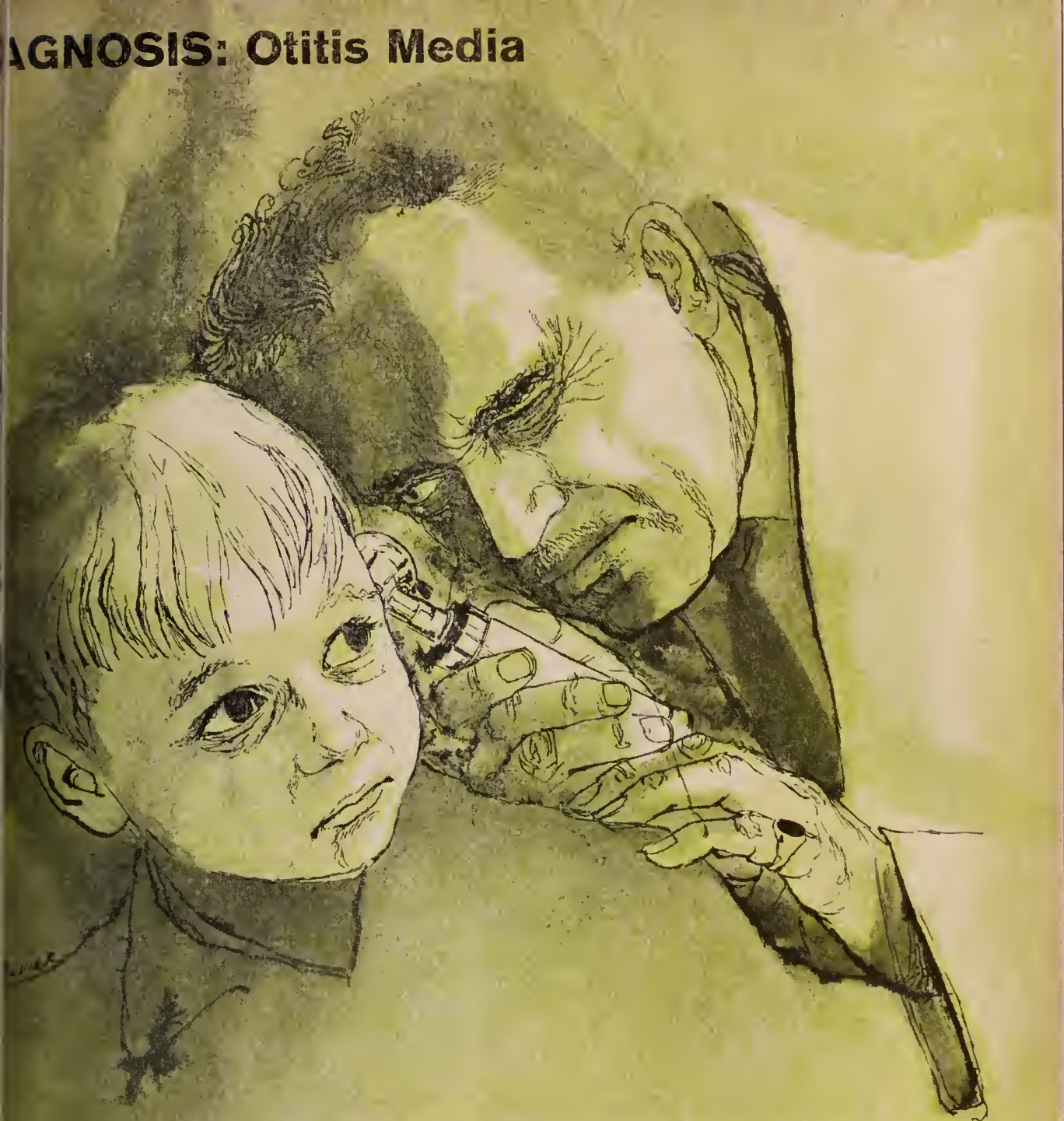
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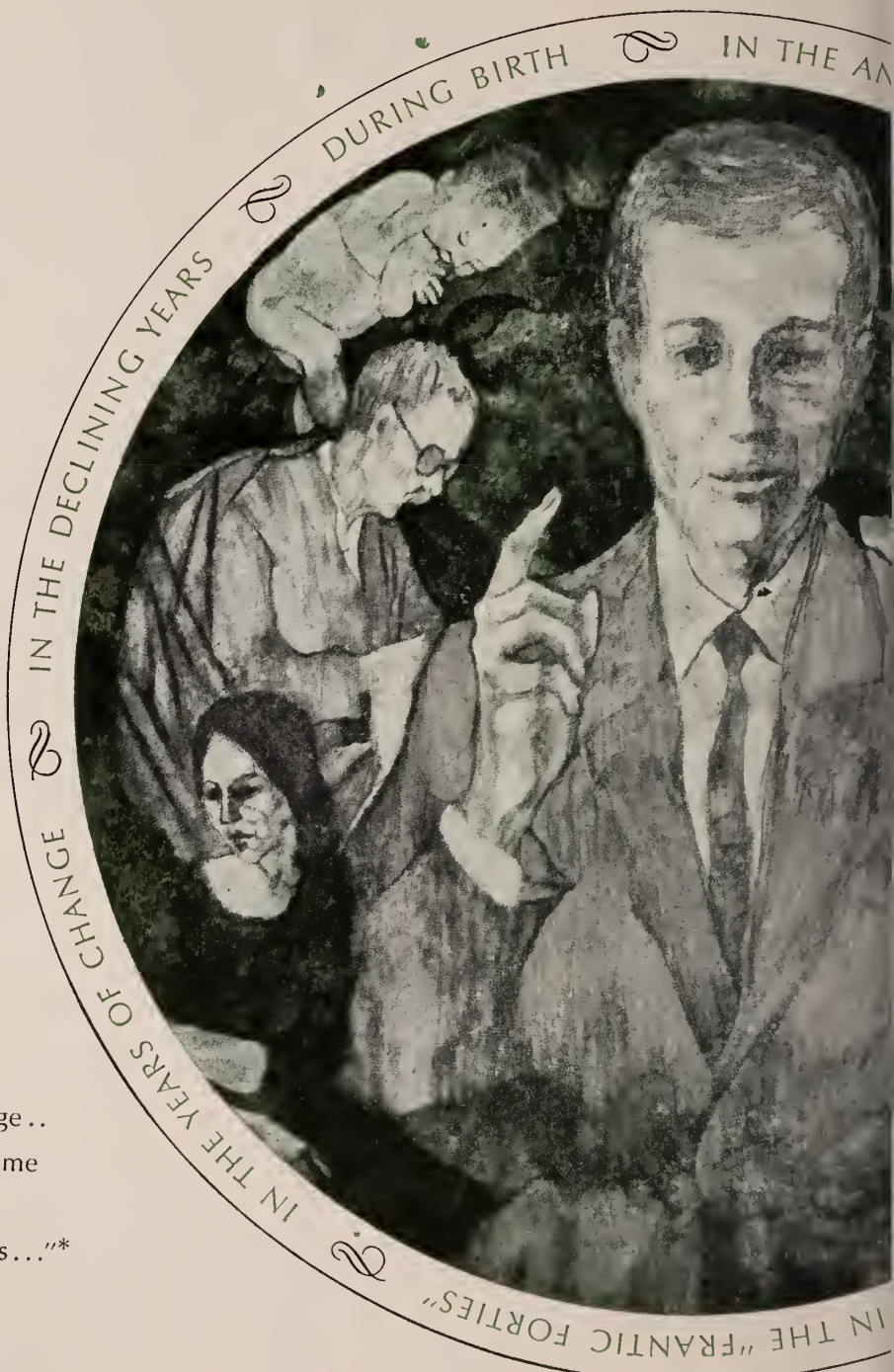
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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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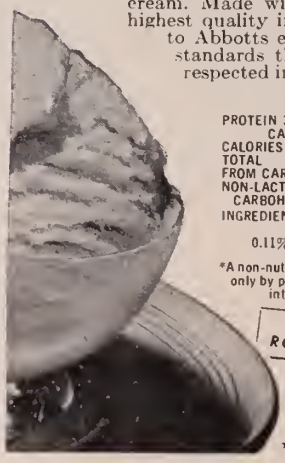
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...or, to be exact, a total of 2,106 ounces in his first two years. And how much he'll need during his first twenty years would have to be measured by the truckload, because the need for the nutrients contained in Florida orange juice continues throughout life.

How our little "limey" or any of your other patients obtain the vitamins and nutrients found in citrus fruits is important to them and to you. There are so many wrong ways, so many substitutes and imitations for the real thing.

For a way that combines real nutrition with real pleasure, there's nothing better than the oranges and grapefruit ripened under Florida's own sunshine. Somehow, nothing can surpass the result of the combination of sun, air, temperature, and soil found in Florida.

It's good nutrition to encourage people to drink orange juice. It's even more judicious to encourage them to drink the juices and eat the fruits watched over by the Florida Citrus Commission. These men set the world's highest standards of quality in fresh frozen, canned, or cartoned citrus fruit and juices.

When you suggest to your patient that they have a big glass of orange juice for breakfast, or for a snack, or when they want to raid the refrigerator, the deliciousness of Florida orange juice will give you assurance that they'll *want* to carry out your recommendation. You'll be helping them to the finest drink there is—by the glassful or the barrel.

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In acne—24-hour-a-day skin care with antibacterial pHisoHex®

(contains 3% hexachlorophene)

In acne, pHisoHex, antiseptic detergent, provides *continuous* antibacterial action against the infection factor. With exclusive, frequent use, pHisoHex builds up an effective antibacterial film on the skin that resists rinsing—lasts from wash to wash. pHisoHex augments any other therapy of acne.

When pHisoHex was used for washing by 42 patients with acne, "the results were uniformly encouraging. . . ."[1] "No patient failed to improve."[1]

pHisoHex cleans the skin of acne patients better than soap because it is forty per cent more surface active. It is a powerful emulsifier of oil, an action particularly beneficial in acne. Moreover, it cleans the orifices of the sebaceous glands, sweat glands and hair follicles more rapidly and more thoroughly than soap. pHisoHex lacks the potentially harmful qualities of soap. It is nonalkaline, nonirritating and hypoallergenic.[2]

For acne, prescribe pHisoHex—and get improved results.

pHisoAc® Cream dries, peels and masks lesions. Use it with pHisoHex washings to help prevent comedones, pustules and scarring. Contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent and hexachlorophene 0.3 per cent.

pHisoHex is available in unbreakable squeeze bottles of 5 oz. and 1 pint—and in combination package with pHisoAc Cream.

1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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New York 18, N.Y.

(1665M)

NEW ANOREXIENT FOR THE "DIFFICULT PATIENT"

"In the cooperative patient, (OBETROL) *was markedly beneficial in producing the desirable weight loss with minimal side effects, even in the case of a high percentage of patients with cardiovascular and other chronic ailments which normally make use of other amphetamines undesirable because of side effects."* [1,3]

"In a group of 100 patients, of whom 60 had diabetes, arteriosclerosis, hypertension, or a combination thereof, we were able to get weight reduction, using (OBETROL) *and diet...With a daily divided dosage of 30 milligrams of* (OBETROL) *we were able to obtain appetite depression without nervous restlessness or insomnia..." 26 patients who previously had been unable to use other amphetamines in any dosage sufficient to maintain the anorectic effect, responded favorably on this medication* [1,3]

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Write for samples and literature.

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(1) Simon, F. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 32-37, Jan. '61.

(2) Plotz, M.: "Modern Management of Obesity, J.A.M.A., 170:1513-1515 (July 25) 1959.

(3) Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med., 907-920, May '61.

* Trademark. A Unique combination of equal parts of Methamphetamine Saccharate, Methamphetamine Hydrochloride, Amphetamine Sulfate and Dextroamphetamine Sulfate. Pat. ‡2748052

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STUDY 3 *Weissberg, G.: Clin. Med. 7:1161, 1960.*

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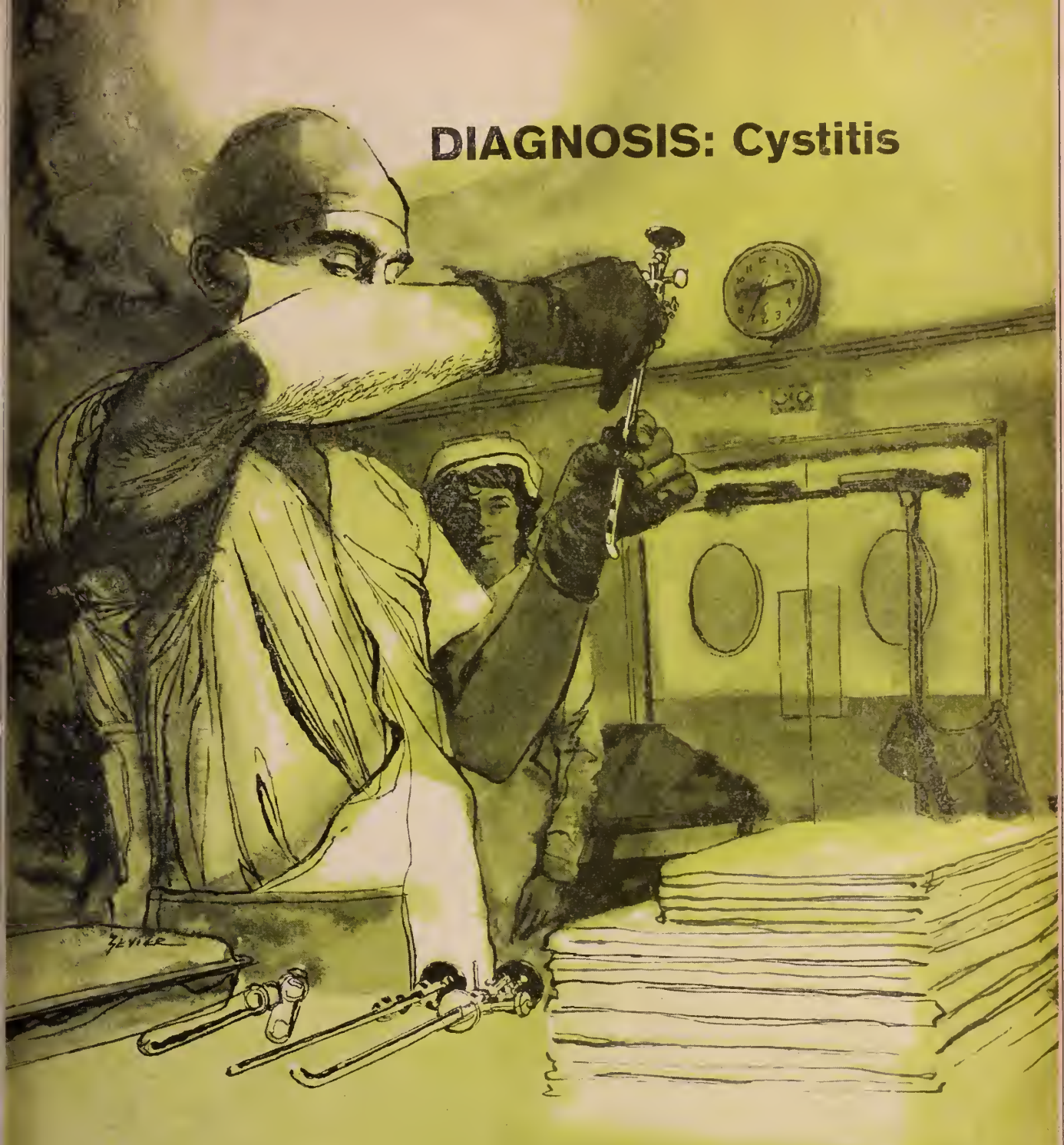
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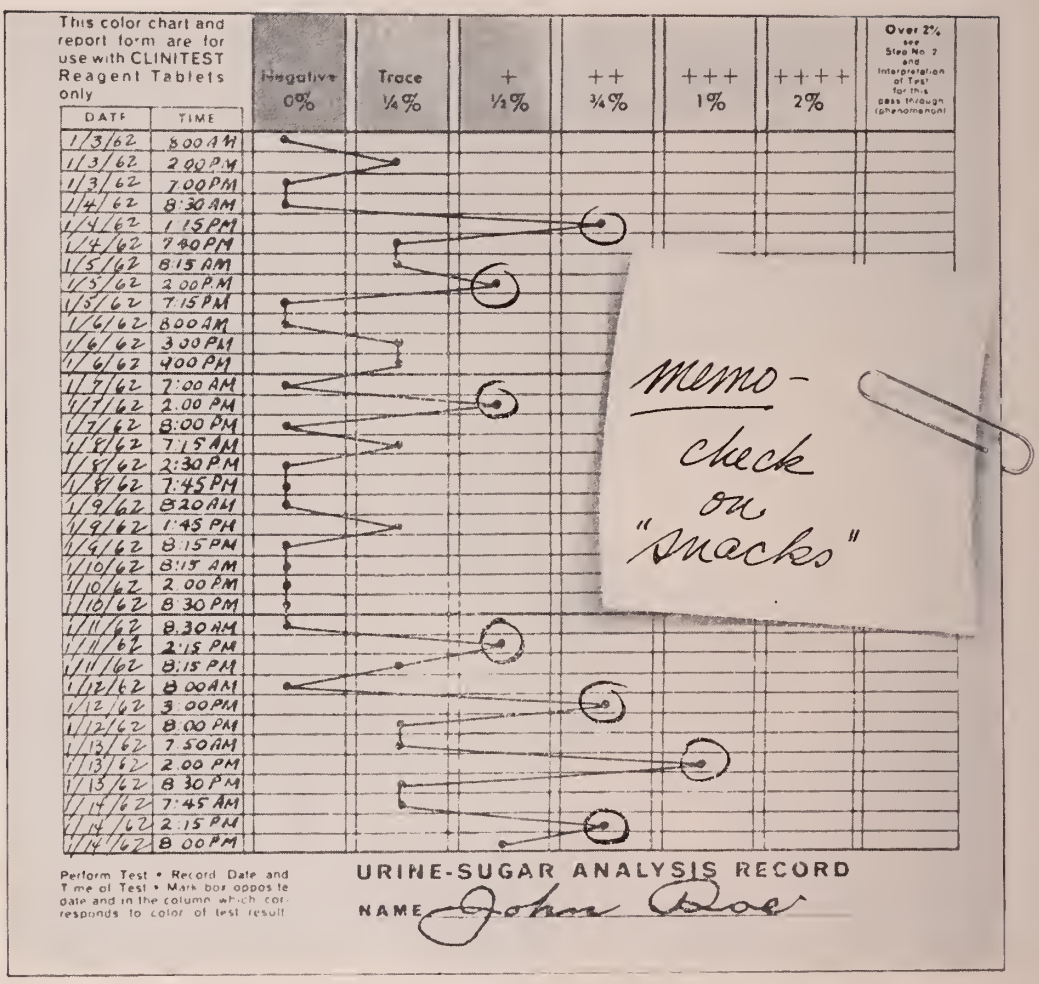
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...literature for additional information about dosage, possible side effects and contraindications.

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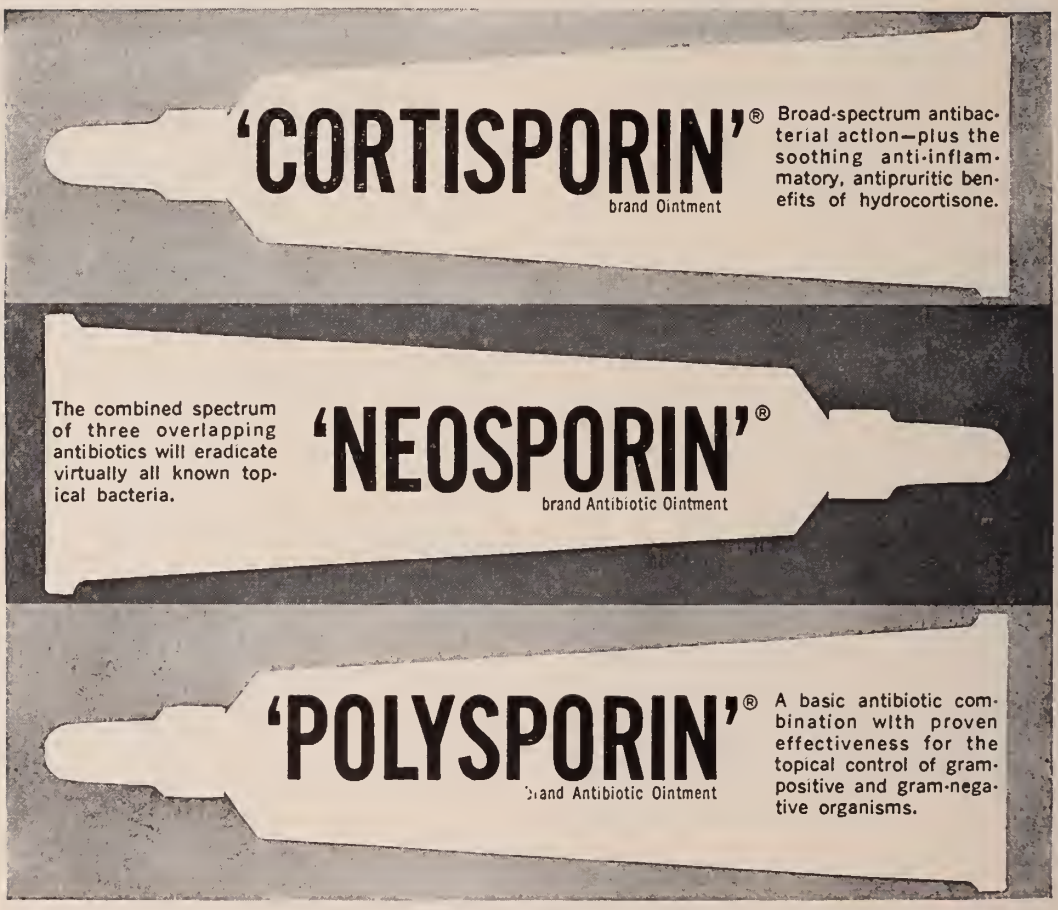
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Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

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In year-long study on peptic-ulcer patients

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*"...faster in onset of action...and for a longer period"**

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Creamalin, trademark reg. U.S. Pat. Off

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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For your elderly patients...

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1 Ford, R. A., and Blanchard, K. Journal-Lancet 78:185, 1958

Formula: In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium para-aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

Also available:
PABALATE, when sodium salts are permissible
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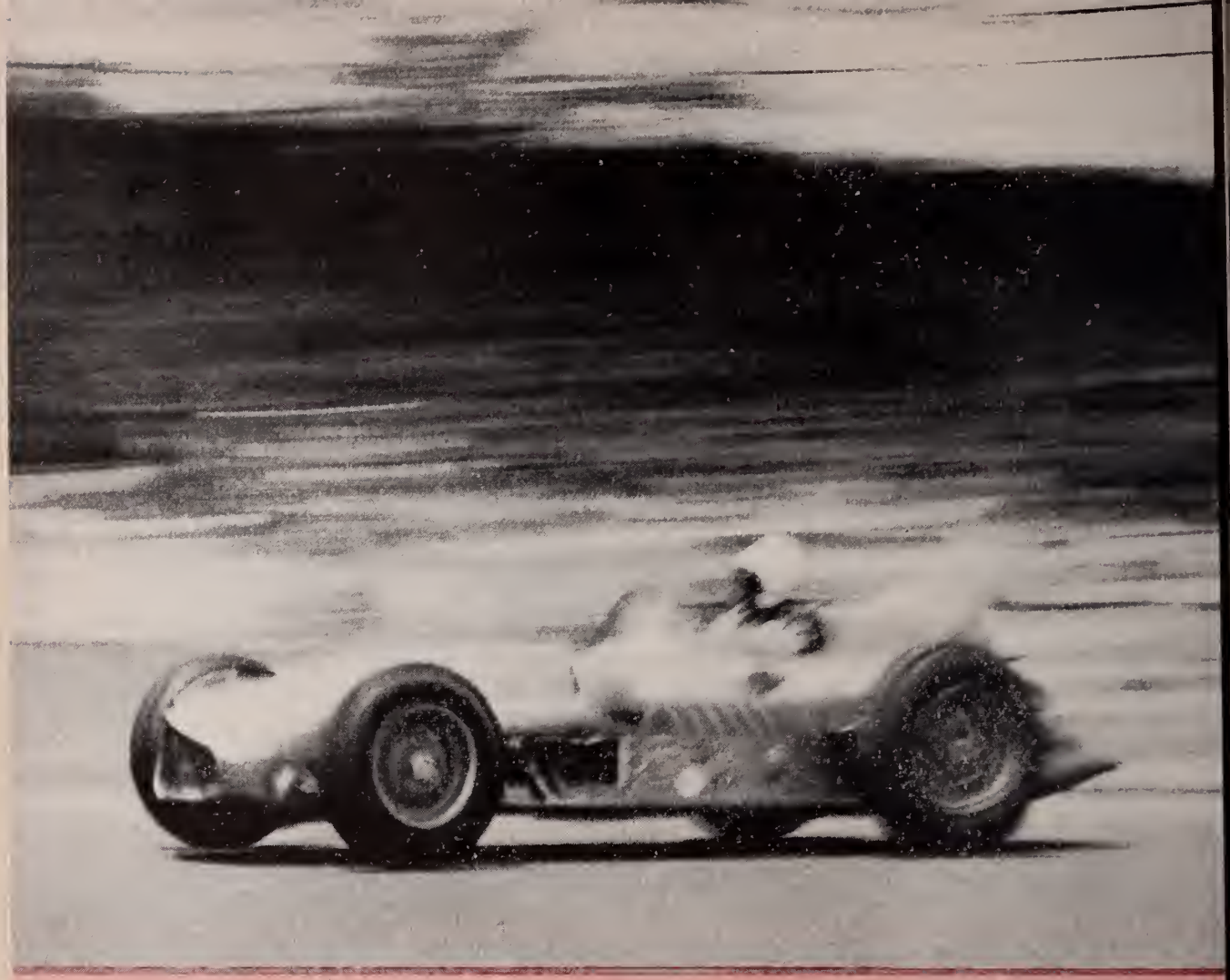
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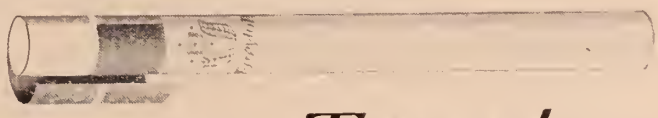
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children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L. : M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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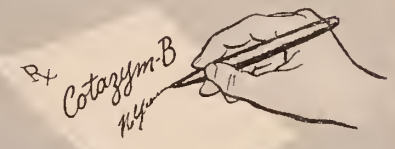
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Dosage: 1 or 2 tablets with water just before each meal.

Organon

REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Kelfer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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Lipancreatin Bile Salts Cellulase



excessive uterine bleeding*

"significant improvement ..."[1]

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CITRUS BIOFLAVONOID COMPOUND	200 mg.
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references: 1. Prueter, G. W.: Applied Therapeutics 3:351, 1961. 2. Taylor, F. A.: West J. Surg., Obstet. & Gynec. 64:280, 1956. 3. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959. 4. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957.

*menorrhagia

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Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

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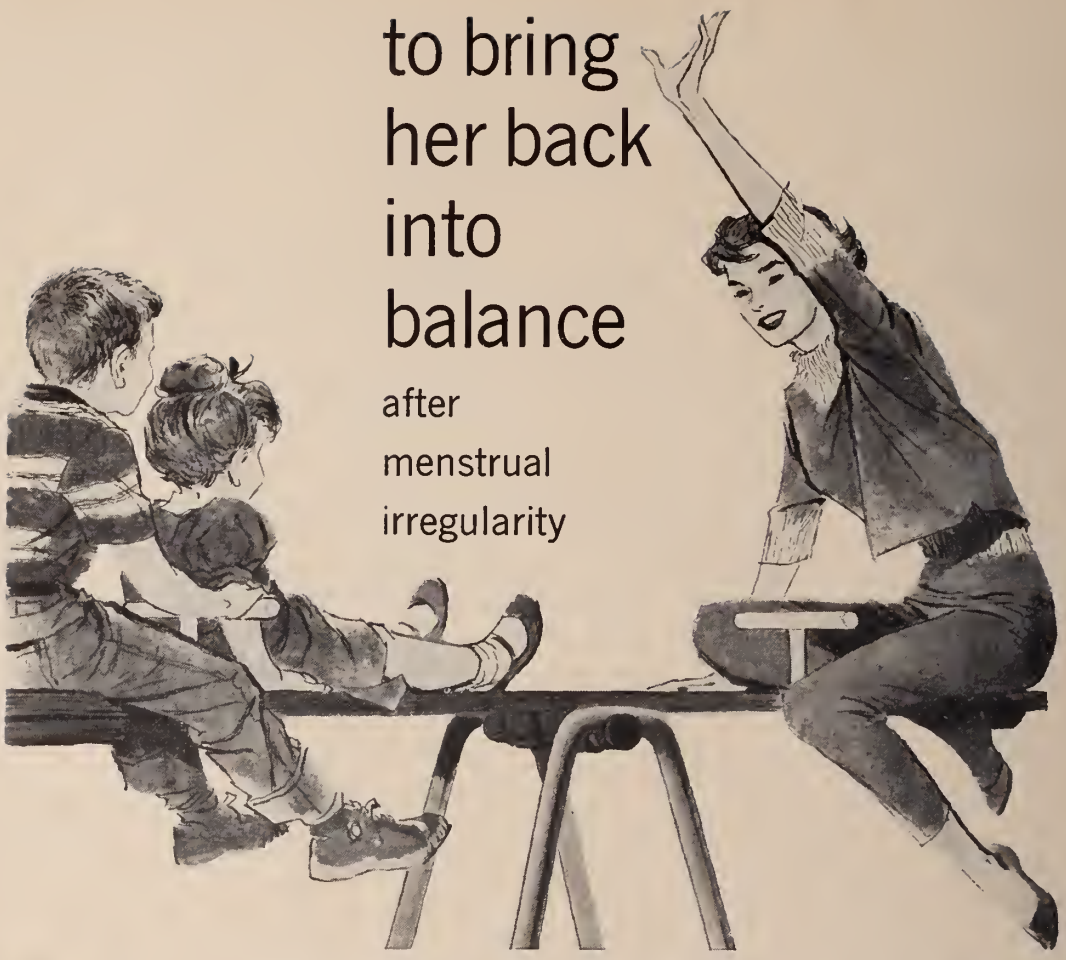
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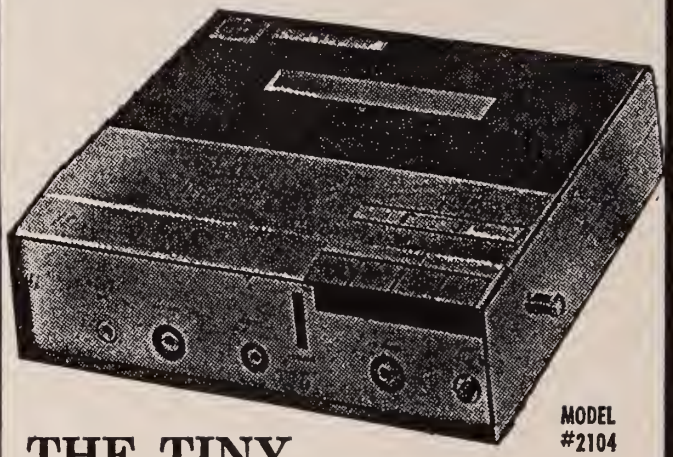
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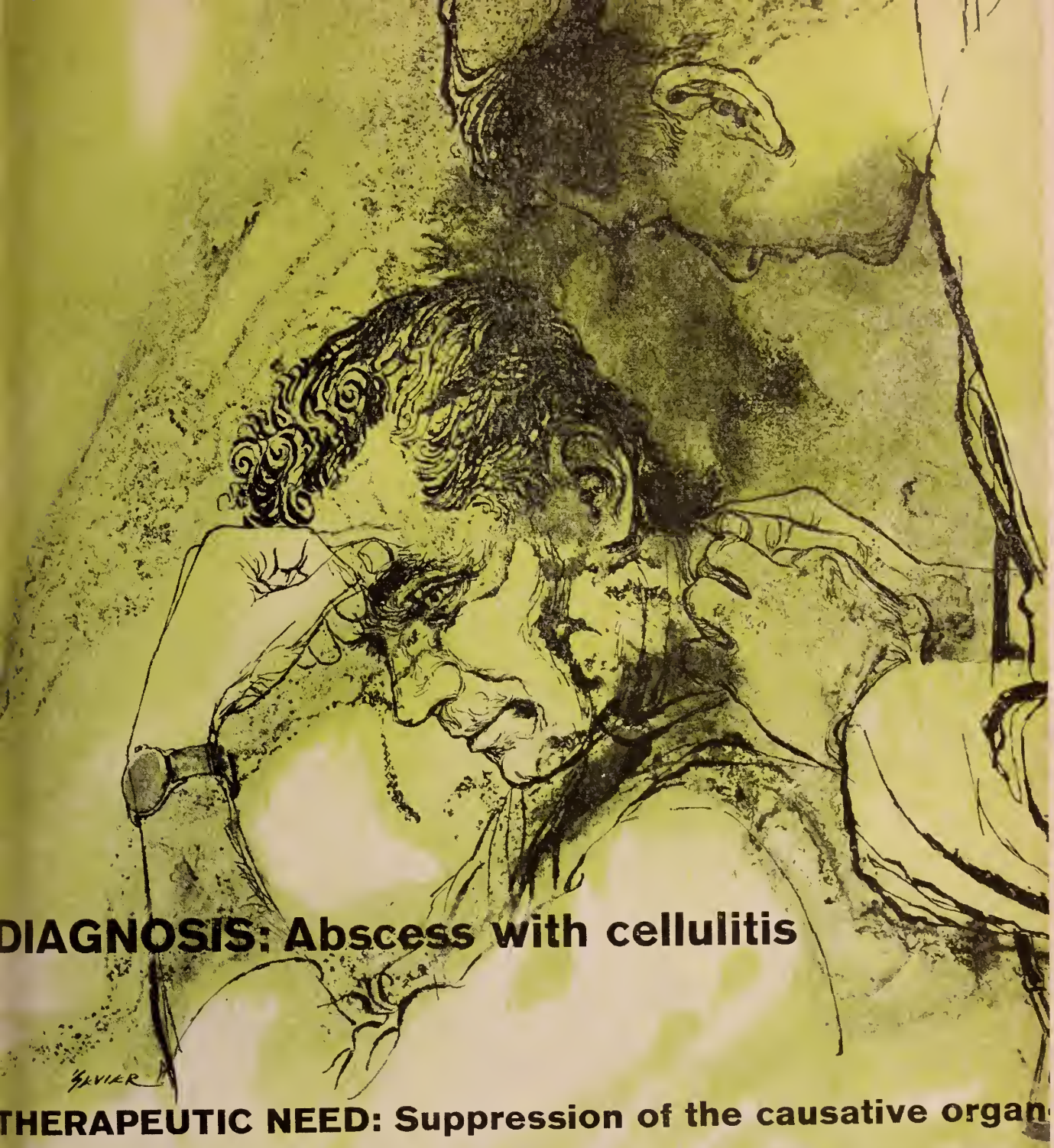
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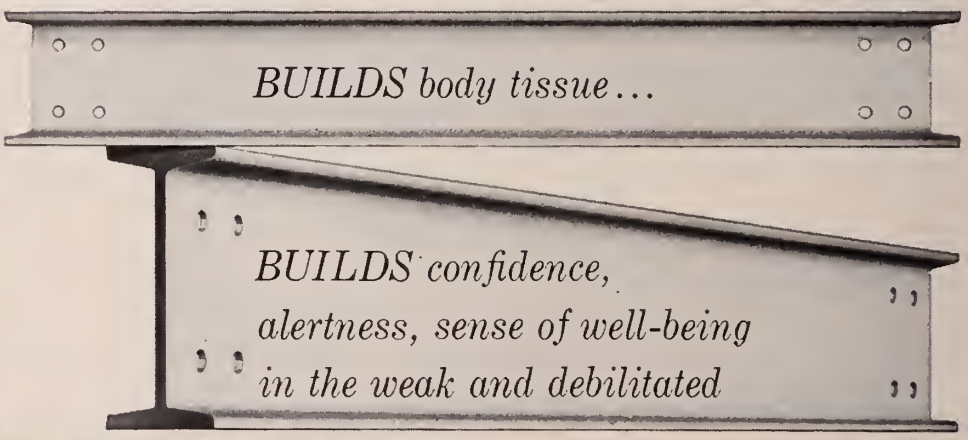
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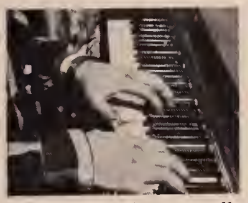
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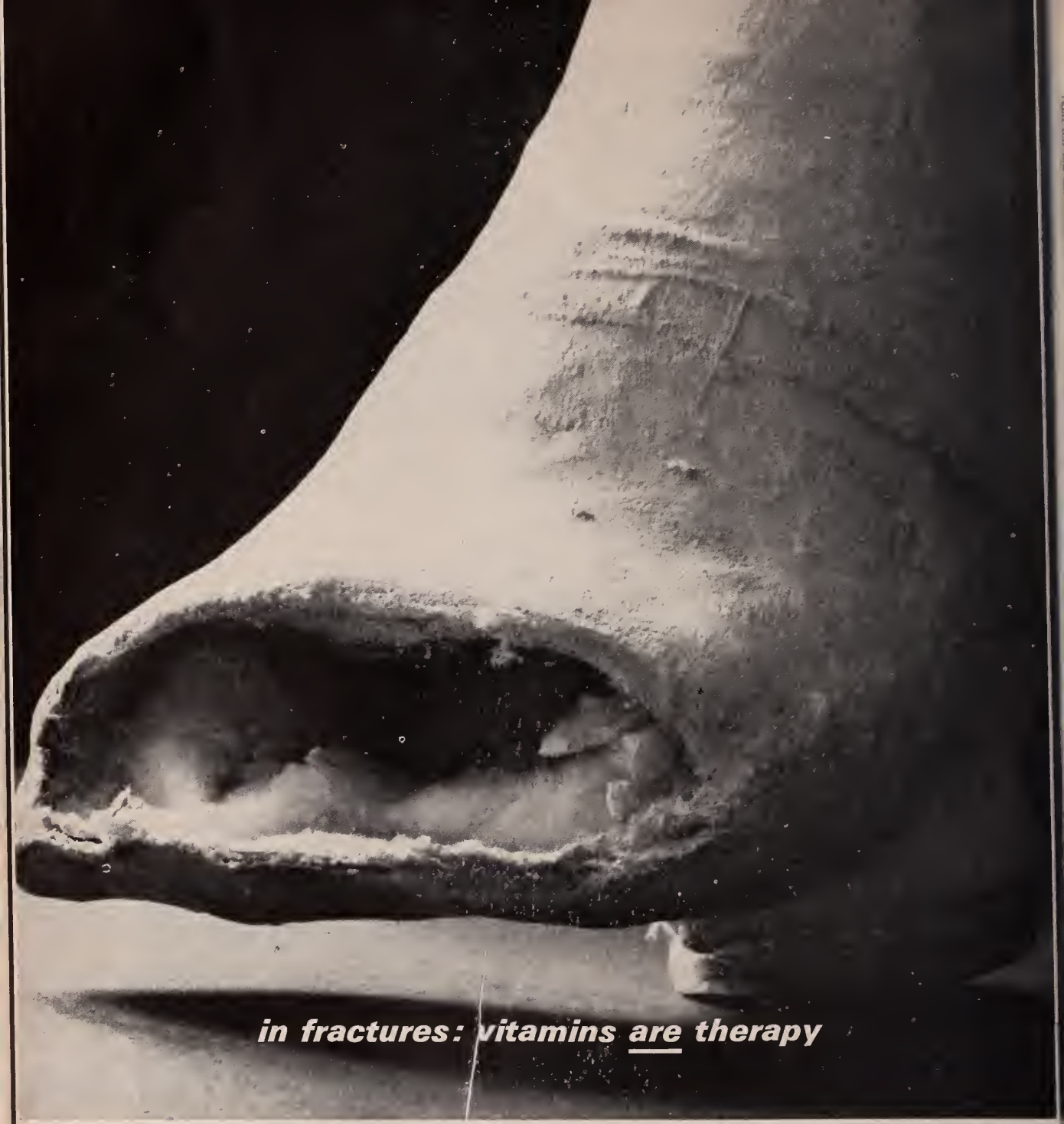
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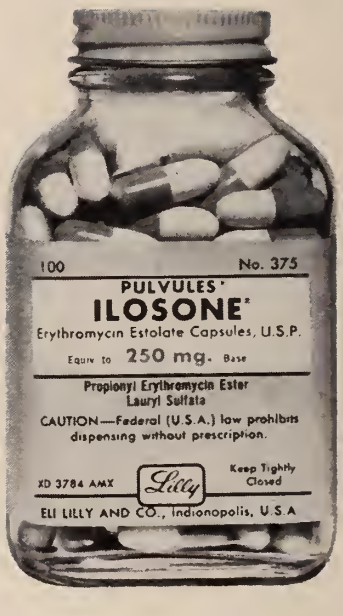
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THE JOURNAL
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Editorials • • •

You and the Annual Meeting

An officer of another state medical society complained recently that their annual conventions suffered from "attendance malnutrition." He lamented for the good old days, offering this interesting description of medical life in the 1920s and 1930s. Then the county medical society, he says, was indeed the "doctors' fraternity," and their annual state meeting was an eagerly anticipated source of professional knowledge and an opportunity to discuss cases and professional problems with former teachers and colleagues in other cities. Those were the days when professional exchange of experience and avid attendance at lectures provided the best avenue for continued medical education. Medical movies were rarely available; TV was the pipe dream of science fiction addicts and access to literature was generally confined to the large communities with good medical libraries.

Now, complains our colleague, doctors think that they do not need to go to state medical meetings for professional learning. Instead, the physician is bombarded with literature; swamped with brochures; interrupted in patient care by earnest detail men. His hospital staff demands his presence at frequent meetings; his specialty group or GP unit seeks his attendance at scientific meetings offering credit or threatening expulsion. The physician of today is either a nomad from his practice, or has to throw up his hands and eliminate all meetings other than three or four each year. His own state medical meeting provides little of the glamour or overwhelming program offering of an A.M.A. meeting. It cannot successfully compete with the social pull of the Las Vegas, Florida or shipboard meeting with its chance for gambling and night-clubbing, within the rules of Internal Revenue.

PUBLISHED MONTHLY SINCE 1904 — HENRY A. DAVIDSON, M.D., *Editor*

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And yet, he insists, a state medical meeting has something of *special* value to the practitioner; something worth preserving. But it cannot survive if physicians by-pass it and restrict their attendance to national meetings of their specialty or area of general practice.

A state meeting, he points out, is the finest "grass roots" medical assembly in the world. It's big enough to provide a stimulating program with out-of-state speakers, and to encourage good scientific exhibits from local hospital staffs or clinic groups. At the same time it's small enough to provide renewed fellowship with former classmates and faculty members to a degree which is lacking in any national conference.

The technical exhibits at a well-run medical meeting have significant educational benefits. Some physicians regard the technical exhibits as "commercialization" of the scientific program, and think that they taint themselves by stopping at any of the booths. Yet physicians should welcome the opportunity to see what new drugs and appliances are being offered, without the pressure of a full waiting room of patients.

None of our exhibits is continued solely on the basis of financial support of the scientific program. We ask no member to lower his scientific standards just to support a commercial exhibit. We do not encourage the "hard sell" among exhibitors at medical meetings. Most of the ethical houses conduct their physician contacts in keeping with the professional standards of those in attendance.

The educational aspects of the modern-day medical exhibit should not be overlooked or derided by the purist who scornfully stigmatizes all commercial displays. The truth is that most of the unquestionably *scientific* exhibits he admires and studies are largely supported by funds from the commercial houses. He gladly accepts the lectures and demonstrations on the scientific program. Without exhibit support, he would have to pay a substantial registration fee.

The public is prone to criticize us for alleged concern with financial returns. Attendance at medical meetings represents a loss of income. What would happen if your patients read this legend on your office door. "To My Patients: I am Attending My State Medical Meeting so I Can Better Serve You. Please call Doctor ..... in My Absence," or let your office explain your absence in a similar manner.

Your state meeting is worthy of your support . . . and it can only remain a vital factor in the life of your state if you attend and take an active role in all aspects of the meeting.

Well—that's what our unhappy colleague out west says. Of course, we have no such worries in New Jersey. Indeed, the world's greatest convention city is in our backyard.

See you in Atlantic City!

Your Role in Disability Determination

On page 265 of this issue we publish an announcement of the Rehabilitation Commission's asking physicians to list themselves as consultants for the Disability Determinations Service. Benefits are available to citizens with certain degrees of disability. In appraising this disability, the State has turned to private practitioners which, most of us agree, is as it should be. If you and your colleagues refuse to participate, the various levels of Government will have to turn to Government employed physicians—and this will lead to the complaint of bureaucratic medicine. We cannot have it both ways. If we want to preserve private practice and discourage the rising tide of bureaucracy, we have an obligation to meet consultant needs like these. Nor are we asked to contribute our work as a public service. Reasonable fees are offered. While the practitioner can probably earn more dollars per hour in his other work, there is, one feels, a duty to show that private practice can do the job.

MARVIN C. BECKER, M.D.
Newark

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Clinical Evaluation of Polythiazide in Congestive Heart Failure*

The quest for a better thiazide diuretic continues. This preliminary study suggests that polythiazide is a potent diuretic, with minimal effects that can be given orally.

A MAJOR breakthrough in diuretic therapy occurred with the introduction of the thiazide diuretics. These compounds have added years of reasonably normal activity to the lives of patients with congestive heart failure. We have had gratifying results with these agents as noted in our first publication [1] on chlorothiazide in January 1958. Our experience broadened [2] with the clinical evaluation of benzydroflumethiazide [3] and later with trichlormethiazide.[4] A new thiazide diuretic—polythiazide†—was made available to us for clinical trial in October 1960. The purpose was to study the efficiency of this agent in congestive heart failure particularly in comparison with other agents in its class and in light of our previous experience. This will serve as a brief report of the results obtained with this compound. Other problems related to fluid retention and hypertension were studied but will not be included in this paper.

METHODS AND MATERIALS

FIFTY patients with congestive heart failure were studied on an out-patient basis. There were 27 males and 23 females whose ages ranged from 21 to 82 years with a mean age of 65. The group included 20 patients with hypertensive arteriosclerotic heart disease; 19 with arteriosclerotic heart disease; 8 with rheumatic heart disease; one with interatrial septal defect and three with heart disease of undetermined etiology.

All but four of the patients had been treated previously with digitalis, low salt diets and other thiazide diuretics, and their congestive failure was considered to be under optimal control. In these cases polythiazide was administered in doses approximately equipotent‡ to whatever diuretics had been used before this trial. Polythiazide was given daily in doses which ranged from 1 milligram to 8 milli-

*As presented at a Conference on Polythiazide, Rye, New York, June 2, 1961.

†Polythiazide was kindly supplied to us by Dr. James L. Garofalo, M.D., of the Department of Clinical Research of Chas. Pfizer and Co., Inc., Brooklyn, N. Y.

‡Two mgm. of polythiazide was considered equivalent to 500 mgm. of chlorothiazide, 50 mgm. of hydrochlorothiazide, 4 mgm of trichlormethiazide and 5 mgm. of benzydroflumethiazide.

1. Becker, M., Simon, F. and Bernstein, A.: Journal of the Newark Beth Israel Hospital, 9:58 (1958).

2. Becker, M. C.: JOURNAL of The Medical Society of New Jersey, 55:427 (1958).

3. Becker, M. C.: Journal of the Newark Beth Israel Hospital, 11:288 (1960).

4. Becker, M. C.: Clinical Experience with Trichlormethiazide. *In press.*

grams. The average dose was 2 milligrams in 40 patients. The patients were seen either bi-weekly or monthly. Dosage was adjusted according to the need.

In 30 patients, serum electrolyte studies were made before and at the end of the study period. Blood was also drawn if clinical symptoms warranted it. The patients were studied from 1 to 7 months with a total study period of 262 patient months. (Table 1)

Patients were evaluated according to weight loss, symptomatic improvement and improvement in signs of congestive failure (such as rate, rhythm, blood pressure, gallop rhythm, rales, effusions, distention of neck veins, hepato-jugular reflux, liver enlargement and peripheral edema).

Results were classified (Table 2) as *excellent* if there was marked clinical improvement in those who never had previous diuretic therapy or if there was further improvement in those who had been considered to be optimal on previous diuretic therapy. Results were considered *satisfactory* if the change to polythiazide in equipotent doses resulted in maintenance of previous optimal status. Results were termed *unsatisfactory* if there was deterioration in the congestive failure as compared to previous diuretic therapy.

TABLE 1.

DURATION OF POLYTHIAZIDE THERAPY

Months	No. of Patients
1 - 2	1
3	6
4	7
5	9
6	19
7	8

Total patient months of therapy — 262

TABLE 2.

CLINICAL RESPONSE TO POLYTHIAZIDE REGIME

	Pts.
Excellent—	
marked clinical improvement in previously untreated cases	4
or	
further improvement in those on previous diuretic therapy	9
Satisfactory—	
maintenance of previous optimal status when changed to polythiazide	36
Unsatisfactory—	
deterioration in status of congestive failure when changed to polythiazide	1

RESULTS

As may be seen in Table 2, excellent results were obtained in 13 patients, *satisfactory* results in 36 patients and *unsatisfactory* results in one patient. Of the 13 excellent patients, four had never had diuretic therapy before and nine had been considered to be under optimal control previously. The 36 *satisfactory* results did as well on polythiazide as on previous diuretic medication and there were indications that thy did somewhat better, thus making our statistics somewhat conservative. In only four patients was it necessary to increase what had been considered to be equipotent dosages, whereas in 21 patients we were able to *decrease* the maintenance dose of polythiazide, sometimes in half and at other times by omitting weekend dosages.

TABLE 3.

WEIGHT CHANGES ON POLYTHIAZIDE REGIMEN

	No. of Patients	
Pounds	Loss	Gain
0	13	13
0.1- 3	12	5
3.1- 5	4	1
5.1- 8	9	0
8.1-10	2	0
10.1-15	4	0

Table 3 reveals the pattern of weight loss in the series. Of the previously untreated patients, weight loss varied from 6 to 12 pounds. In previously treated patients there was a variation from no weight loss up to a loss of 15

pounds. Six patients gained weight. The one patient who gained 3 to 5 pounds was considered as an *unsatisfactory* response but the five others who gained weight were counted as satisfactory because this did not seem significant in light of good clinical conditions and because alleviation of congestive failure may cause an improvement in appetite and a gain of flesh. It will be noted that 31 patients lost weight varying from 3 to 15 pounds. Of these, four previously had been untreated, leaving 27 patients who had further weight loss when transferred to polythiazide.

In no patient did resistance to the drug develop.

Blood pressure was maintained at satisfactory levels in those hypertensives who had been previously controlled with other thiazide diuretics. In some the response seemed to be highly gratifying with further reduction in systolic as well as diastolic blood pressure.

SIDE EFFECTS

SIGNIFICANT side effects were few in this series of patients. (Table 4) In no patient was the drug permanently discontinued. Weakness was found in three patients, unusual fatigue in one, leg cramps in two, abdominal cramps with nausea and anorexia in two. The only one of these patients with unusual fatigue had a serum potassium drop to 3.7 mEq. per liter. In the other patients there was no correlation with electrolytic findings. In general, hypokalemia was not a problem but patients were always advised about a diet rich in potassium. In those subjects in which higher doses of polythiazide were used and in those with symptoms of potassium loss, no matter what the serum potassium, potassium chloride was added to the regimen in a dose of one Gram three times a day.

Arrhythmias developed in two patients, one a bigeminal rhythm and the other a complete heart block. In the patient with bigeminal rhythm, quinidine sulfate was ineffective and then digitalis and polythiazide were withdrawn.

TABLE 4.

SIDE EFFECTS OF POLYTHIAZIDE THERAPY

	Pts.
Weakness	3
Unusual fatigue (serum K = 3.7 mEq.)	1
Leg cramps	2
Abdominal cramps, nausea and anorexia	2
Arrhythmias	
Bigeminy	1
Complete heart block	1
Diabetes mellitus and jaundice (associated Tofranil® treatment)	1

After one week, the bigeminy disappeared and therapy was reinstituted with smaller doses of polythiazide. No recurrence of the bigeminy has been noted in the past four months. In patients with the complete heart block, digitalis and polythiazide were discontinued with return to normal sinus rhythm. This was not the complete solution, however, because a month later, this patient developed complete heart block with Stokes-Adams syncope and needed ephedrine, steroids, isopropylarteranol, *and polythiazide* for what at best is only partial control.

In the 30 patients in whom serum electrolytes were drawn before and after the study, the values for sodium ranged between 138 mEq. and 145 mEq. per liter; for potassium between 3.7 and 4.7 mEq. per liter and for chlorides between 98 and 107 mEq. per liter. No significant changes occurred in these ranges except for the one patient mentioned above. In no patient was there a rise in the blood urea nitrogen.

In one 72-year old patient who had a previous myocardial infarction, sudden death occurred after 5½ months of effective control of his congestive heart failure.

One patient developed jaundice and diabetes mellitus a week after initiation of polythiazide and imipramine hydrochloride for congestive failure and depression. Hospitalization was advised in order to investigate the problem further. If hospitalized it must have been under the care of another cardiologist. He was lost to follow-up.

No hematologic, renal or skin complications were noted in this series of patients.

SUMMARY

1. Polythiazide† was administered to 50 patients with congestive heart failure with the majority being treated for a period greater than six months.

2. Satisfactory to excellent results were obtained in 49 of the 50 patients.

3. Almost all of the patients responded as well to polythiazide as to the previous thiazide diuretics used, and a significant number seemed to demonstrate a better response.

4. In 21 patients, one could decrease the dosage of polythiazide below what had been considered to be equipotent doses of other thiazide diuretics.

5. In 27 patients, further weight loss occurred when patients were transferred from previous thiazide diuretics to polythiazide, suggesting increased efficiency.

6. Electrolyte disturbances were rarely encountered and can be avoided by judicious therapy.

7. Polythiazide is a potent, orally effective diuretic with minimal side effects.

299 Clinton Avenue (Dr. Becker)

Is Reckless Driving a Disease?

The December 1960 *Today's Health* carries an article by E. L. Barcella which reports on a study seeking to find out if reckless driving is a disease. The project is considered a first step for refining the physical criteria for determining qualifications for a driver's license. Such criteria would be needed by authorities to invoke sterner control measures and, if challenged, to produce scientifically valid proof that would stand up in court.

From 20,000 to 25,000 Connecticut motorists will undergo a voluntary screening in a specially built six-room mobile clinic to determine if there is a relationship between their physical, physiologic or psychologic conditions and their driving records, with the emphasis on physical factors. Each will be tested for hearing and vision deficiencies, diabetes, anemia, and heart and lung pathology. Later, the investigation will be extended to physiologic factors, such as the effect of drugs on drivers, and psychologic factors, such as the effect of drivers' emotional attitudes on their driving.

The U. S. Public Health Service is conducting the experiment in the field which will take 18 months. The follow-up task of keeping tabs on the records of the drivers who have been examined will be done by the State Motor Vehicle Department and will take five years.

Former Governor Ribicoff of Connecticut is quoted as saying that the study "is exciting to health authorities because, for the first time, it gives them an opportunity to determine whether methods they have used successfully against various diseases will work against the plague we know as the traffic accident; it is equally exciting to all who are interested in highway safety because of the lifesaving promise it holds."

Today's Medical Economics

One of the critical problems facing medicine today is the growing tendency of the working man to equate health care with a municipally owned service while at the same time demanding discount house prices.—Justin C. Smith, Western Reserve Univerity.

Rita S. Finkler, M.D

Millburn

Luteal Deficiency in Sterility*

Therapy with a New Hormone

Fourteen out of thirty-two "sterile" patients were able to conceive after medroxy-progesterone acetate therapy. Dr. Finkler here discusses the rationale of this program.

A childless couple applying to a physician for alleviation of sterility, whether primary, secondary or because of inability to carry the child to full term receives a sterility 'work-up' in conformity with the standards elaborated by the American Society for the Study of Sterility. The procedures are explained to the couple and in most cases full cooperation is obtained. These investigations reveal the etiologic factors in the male, the female, or both potential parents. These factors fall into three main categories:

1. Constitutional and organic disturbances
2. Endocrine disturbances
3. Psychogenic factors

Environment and nutrition play an important part in the overall picture and are always given full consideration.

This presentation is chiefly concerned with one aspect of endocrine disturbances: the luteal phase or progestational deficiency.

The role of the corpus luteum in female physiology has been known for a long time, but it was Corner [1] and his associates, Hamblen [2] and others who made progesterone available commercially. This hormone and its synthetic derivative have been used extensively with or without estrogens in many conditions where progestational deficiency could be demonstrated. Its usefulness has been demonstrated in functional ovarian disturbances, such as amenorrhea, functional uterine bleeding, spontaneous abortions and prematurity. The disturbances may be due to such factors as heredity, constitutional diseases, genetic defects, nutritional defects, or emotional factors. A thorough analysis includes consideration of these factors which may be present alone, or in connection with luteal defects.

Possible luteal defects or progestational deficiency are demonstrated by standard tests including endometrial biopsies, cyclical vaginal smears, basal body temperature graphs and the estimation of urinary pregnanediol.

These studies now constitute an integral part of general analysis in female sterility. If a defective luteal phase can be demonstrated as a major factor in sterility, treatment with progestational hormones is indicated.

A group of 32 patients were studied in whom luteal phase defects were considered to play a major role in sterility, habitual or multiple abortions, threatened abortions and prematurity. All these patients received standard sterility studies including gynecologic examina-

*This preliminary report was assisted by a grant from the Upjohn Company of Kalamazoo, Michigan. Dr. Finkler is a consultant in endocrinology at the Newark (N.J.) Beth Israel Hospital.

1. Corner, G. W.: Contrib. Embrol., 31:117 (1945).
2. Hamblen, E. C.: Endocrine Gynecology. Springfield, Illinois, 1939, Thomas.

tion, endocrine investigations, basal metabolic rate, serum cholesterol, protein-bound iodine, urinalysis, blood count and the following fertility studies: tubal insufflation, hysterosalpingogram, cyclical vaginal smears, endometrial biopsies or premenstrual curettage. When indicated, special hormone studies were carried out, such as pituitary gonadotropins, 17 ketosteroids, adrenal steroid partition studies and pregnanediol determinations. The latter was particularly important in patients who had had one or more abortions, miscarriages and prematurity. Nineteen pregnanediol studies were carried out in this group.

Patients with demonstrable gynecologic disturbances were not included in this survey. In a few cases, previous gynecologic surgery was judged to have completely or partly corrected the pre-existing pelvic pathology and did not constitute the major factor in the patient's sterility. In all cases, the status of the husband had been thoroughly investigated. Wives of men with azoospermia, marked oligospermia or necrospermia were excluded from this survey. Progestine therapy was evaluated by the improvement in vaginal smears, B.B.T. graphs and endometrial response.

If pregnancy did not occur in spite of a favorable response, other factors must be considered as partly responsible for failure to conceive. This evaluation is applied to patients with varying degrees of pelvic pathology present in addition to demonstrable luteal deficiency.

This group of patients came from the author's private practice. Histologic studies of the endometrium and pregnanediol estimations by paper chromatography (method of Bongiovani) were carried out in the laboratories of the Newark Beth Israel Hospital.

THERAPY

When luteal phase deficiency was considered to be the major factor in infertility, therapy was instituted in the following manner. Tablets Provera,† 10 milligram, were given once a day for ten days starting on the 15th or 16th day of the cycle for three or four cycles. Results were checked by B.B.T. graphs, vaginal smears and repeated endometrial biopsies when possible. When conception occurred Provera® therapy was continued for the first two or three months of pregnancy. If the patient had had previous abortions, therapy was continued and increased to 20 and 30 milligrams a days as pregnancy advanced. In threatened abortion, intramuscular injections with Depo-Provera® 50 milligrams, were given daily or twice a day in addition to oral medication until bleeding stopped.

In addition, the patients received vitamin supplements and thyroid therapy when indicated.

None of the patients in this group showed definite thyroid deficiency. In cases with repeated abortions, previous therapy with thyroid preparations did not prevent abortions.

In all, 32 patients were treated in this group. They were divided into the following categories:

1—Patients with a history of one or two abortions (10 cases)

2—Patients with 3 or more abortions each (2 cases)

3—Patients with threatened abortions (5 cases)

4—Patients with functional sterility (15 cases)

For analysis of the results of Provera® therapy in these groups of patients see the table.

1. ONE OR TWO ABORTIONS

Group 1 included 10 patients who gave a history of one or two abortions and showed evidence of luteal deficiency in smears, endometrial biopsies, B.B.T. graphs and pregnanediol excretion either before or during early pregnancy.

Only one of the ten showed a normal pregnanediol excretion (Case 9).

†Provera® is Upjohn's registered tradename for their brand of medroxy progesterone acetate.

THERAPY WITH MEDROXY-PROGESTERONE

Group	Patients	Characteristics	Therapy in Months	Luteal Phase		Pregnancies	
				Improved	Not Improved	Full Term	Miscarriages
1	10	One or two abortions	2 to 6	10	0	3	2
2	2	Three or more abortions	3 or 4	2	0	2	0
3	5	Threatened abortions	3	0	5	4	1
4	15	Functional sterility	2 to 6	11	4	5	0
TOTAL	32	All types	2 to 6	23	9	14	3

Five patients in this group conceived.

Three patients carried to full term and delivery.

Two ended in a miscarriage.

2. HABITUAL ABORTIONS

ONE patient had a history of three miscarriages; the other of four miscarriages.

Both patients showed subnormal pregnanediol values during early pregnancy. In both pregnancy was maintained by Provera® therapy orally. Both delivered at full term; one had twin boys.

3. THREATENED ABORTION

THERE were five patients with threatened abortion. Four are now being maintained by Provera® therapy orally and by intramuscular injections; the latter is used in patients with more severe manifestations of threatened abortion as a supplement to oral medication.

One patient was carried on this therapy for 3½ months, but miscarried at 6½ months' pregnancy. The baby lived 2 hours. This patient will be later investigated for an incompetent internal os, as she was losing amniotic fluid gradually for two months prior to the miscarriage. Because of the bleeding off and on, urinary pregnandiol studies were not carried out.

4. FUNCTIONAL STERILITY

GROUP 4 consisted of 15 patients. The chief etiologic factor in sterility in this group was luteal deficiency, as diagnosed by vaginal smears, endometrial biopsies, B.B.T. graphs and pregnanediol determinations when indicated.

In all but one, the pregnanediol excretion was below normal.

In eleven patients in this group, improvements in luteal phase was achieved with Provera® therapy. Five patients conceived and six showed normalization of the smear patterns, and a change from monophasic to biphasic B.B.T. graphs.

SUMMARY

MEDROXY-PROGESTERONE acetate is a potent oral progesterone of value in functional sterility, repeated, habitual and threatened abortions, where luteal deficiency constitutes the chief factor of the ovarian dysfunction.

116 Millburn Avenue

Dryden P. Morse, M.D.

Moorestown

The Implantable Pacemaker

The science fiction writers have long conjured up the replacement of bad hearts with good ones; and, as often happens, science is beginning to catch up with science fiction. The old phrase "his heart's in the right place," may soon acquire a different meaning.

In the last year, cardiac surgery has added a new instrument to its already formidable and heterogeneous inventory. To the long list of new operations on the valves and septa of the heart made possible by extra-corporeal circulation with perfusion hypothermia, there may now be added a significant and "different" *closed* heart operation: implantation of a semi-permanent electrical pacemaker for patients with symptomatic bradycardia due to heart-block.

This apparatus, now available from several companies, consists simply of mercury-magnesium batteries with a life of five years; transistorized circuitry which emits an eight to 14 volt pulse at a present rate of 55 to 70 per minute; and insulated connections to a bipolar electrode to be implanted into the myocardium of either ventricle. The batteries and circuitry, together the size of a cigarette pack, are embedded in an epoxy resin and coated with a leak-proof silicone rubber capsule. After the electrode is fixed in the heart, the batteries and circuit are placed subcutaneously to be readily accessible.



An x-ray view of the pacemaker in one of our patients showing capsule, batteries, circuiting and bipolar myocardial electrode.

Originally, with all types of pacemakers, there was continuous increase in threshold due to fibrosis. Within this new bipolar electrode, however, after an initial threshold increase during the first six weeks, a plateau is reached which remains constant for as long as a year and a half (the maximum period of observation). It is now considered practical to implant the pacemaker all at one time instead of having an initial period when the heart is connected to an external apparatus. This is preferable to avoid infection, according to Zoll and Chardach, who are among the pioneers in this field.

Among my patients rehabilitated by the pacemaker are a 29-year old man with a complete heart block (rate 38 to 42) following the complete correction of the tetralogy of Fallot (cyanotic type) by open heart surgery and profound hypothermia; a 50-year old plumber with a severely symptomatic complete heart block (rate 30 to 40) due to arteriosclerosis; and a 63-year old housewife, who had been repeatedly hospitalized for failure in spite of digitalis and diuretics with a rate of 30 to 38. Her pulse is now a steady 72.

The recent successful implantation of complete prosthetic aortic and mitral valves into the heart, together with this implantable pacemaker represent two more steps toward the far-off days when an implantable electrically-driven prosthetic heart will be an actuality.

500 Chester Avenue

Change in the Status of the Aged

In February 1962, the Senate Special Committee on Aging under chairmanship of Senator McNamara of Michigan reported that:

1. In 1920, one-third of the aged were employed. Today, only a fifth are employed.
2. The potential voting power of the aged has nearly doubled in 40 years. In 1920, only 8 per cent of the voting age population was over 65 years of age as compared with 15 per cent today.
3. Between 1920 and 1960, the number of persons over 65 years of age increased 236 per cent, those over 75 increased an "extraordinary" 279 per cent, and those over 85 increased a "phenomenal" 920 per cent. As of 1960, there were nearly 1 million Americans 85 and older.
4. The number of widowed, divorced and single women over the age of 65 has increased 40 per cent in the past decade alone until they now number 5.7 million persons. Aged men in the same categories have shown "hardly any increase at all" in absolute or relative numbers.
5. The aged population is expected to more than double in the next 40 years.

Meanwhile, according to the Bureau of Census, out of a total population of 179 million, some 16.5 million (roughly 9 per cent) were age 65 and over in 1960.

According to the Health Information Foundation, the projected increase in population of people over 65 will force large investment in new hospitals and require appraisal of community bed needs. This appraisal challenges every community in terms of avoiding the construction of limited facilities that may, of necessity, be substandard.

Fumes Can Cause Lead Poisoning

Seven scrap metal workers suffered lead poisoning while using torches to cut heavily painted steel bridge girders, according to a report in the Journal of the American Medical Association for January 21, 1961. Written by F. E. Zimmer, M.D., the paper stated that a very high concentration of lead was found in the fumes created by the work.

Paint chipped from the girders contained 22 per cent lead. Samples of air taken where the men were working contained up to 20 times the maximum allowable concentration of lead.

Several of the men became ill within one week of starting the work and all seven were poisoned within five weeks. All showed classical symptoms of lead poisoning, including gagging, nausea, loss of appetite, muscular weakness, generalized aching, and fatigability. Two required treatment. Both recovered.

"In this day of extensive construction and renovation and with reclamation of scrap steel a steadily increasing business it may be anticipated that this mode of rapidly developing lead poisoning will become more important," said Dr. Zimmer.

Phoebe Hudson, M.D.

Irving M. Levitas, M.D.

Westwood

A New School Health Program in Practice

Spelled out here is a blueprint for better cooperation between private practitioners and school physicians; and better cooperation among the members of the school health team.

In August 1959 this Journal published an article of ours called "The New Look in School Health Programs." At that time, an attempt was made to summarize the up-to-date ideas in this field.

Since 1957, these ideas have been gradually put into effect in the Emerson Public School system in Bergen County, New Jersey. This present paper outlines the implementation of the program, describes the problems encountered, and reviews what has been accomplished.

Prior to 1955, the school health team consisted of nurse, physician and dentist. The school prided itself on having as many children as possible examined in the school. A psychologist, when needed, was brought in on a *per case* basis. There was no remedial reading teacher. This was not much different from most of the other schools in New Jersey. Spurred by the population boom in Emerson, it became obvious that needs were not being met. Shortly thereafter a psychologist and remedial reading teacher were hired full time.

During the next two years the newer concepts of school health programs were discussed with the Superintendent and principals. With their enthusiastic support, meetings were held with the Board of Education, teachers, and PTA. Many of these sessions were well reported in the local press. Arousing interest by conveying accurate information to the involved people and the community in general is absolutely essential to the success of a new school health program. However, the initial reaction of many people was that the doctor was trying to escape work by not doing the routine physical examinations. It was necessary to convince them that the needs of school health lie elsewhere than in routine work; and that the doctor will be just as busy, if not more so, in essential, needed, problem areas.

Once the new program was accepted, letters were sent to all doctors in the area explaining it and informing them that children would be coming *to their offices* for regular school checks. The letter stated that the families had been urged (at the meetings and *via* notes from the school) to request complete physical examinations. (Not, "Would you sign my child's school card?")

The response was gratifying. The figures below show the comparison between 1957-1958, when the old system was still in use; and 1960-1961 when the new routines were in effect.

1957-1958

The total school population was 899. Four grades were to be examined: 255 examina-

tions. Of these, 169 were done in the school; 37 went to the family doctor; 2 were excused for religious reasons and 47 were never reported. Excluding the 47, that means that 63 per cent of those accomplished were done by the school physician. A survey during the school examinations showed that *no significant defects were found which had not previously been known to the mother* and/or the school. (Wax in the ears, and so on, not included.)

1960-1961

THE total school population was 1105. Four grades were to be examined: a total of 530 examinations. Of these 118 were done in the school; 409 went to the family doctor, and three were not reported. Thus, 22 per cent were done by the school physician. This figure is higher than would be expected because 47 athletic examinations done in the school were accepted as "regular checks." Otherwise, most of these students would have gone to their family doctor. In three years the figure of 63 per cent dropped to 22 per cent by school physicians.

This brought about many changes. More thorough examinations were done in the school because there was more time. The number of defects discovered increased markedly. However, it is unfair to draw specific conclusions about this because too many other factors influence it. For example, the total school enrollment had increased. The reading teacher alone reported 79 kindergarten children included in the 1960-1961 figures; and the 1960-1961 figures for defects include not just those *found* in those years but *all* defects known, and some had been known for years.

The school nurse, who has made up these reports for years, and the school physician are sure that more defects *are* being reported. This is partly due to the activities of the school psychologist and reading teacher; plus general teacher awareness. It is also due to better reports from family physicians who may be aware of defects of early origin or family tendencies; and who are giving more thorough information as they realize they form an important part of the school health program.

Meanwhile, under the Superintendent's direction a referral system had been set up to pick up problems of any nature and carry them to as adequate a solution as possible.

Essentially the flow is as follows:

(1) Teacher to principal to nurse to physician (and/or dentist) to psychologist (and/or reading teacher); to family physician; to referral agency.

(2) The child's family participates at any point along this chain—either originating the inquiry, or (more often) hearing about it and acting on it.

(3) The Personnel Committee also fits into this chain.

By this system, the teacher would set into motion a chain of activity which brought about evaluation as the problem demanded. Some problems were settled quickly between teacher and principal. Others progressed through a fairly complete study involving the whole group. The family was told of the problem at the very outset of its consideration.

The school physician visited the school at regular intervals. Any problems or "work-up cases" were scheduled for this time so that a busy morning with valid problem children was the routine rather than a series of machine-line fruitless physical examinations.

The "simpler" problems seen by the nurse and doctor were on this order: suspected deafness; chronic "runny" noses; eczema; hoarseness due to massive tonsils; "bumps on the head" which were normal suture lines, and so on. Twenty of these were described during the year.

More serious problems were usually referred to the medical department *via* the teacher and principal. A complete physical examination was done in a private room. Every effort was made to have the mother present. The problem had previously been outlined on a reporting sheet to the nurse. A meticulous physical examination was accomplished. Comments as to a possible physical cause were reported. Most of the cases were then seen by the psychologist. The family doctor was informed by telephone by the school physician that his pa-

tient had presented a problem in the school and was being evaluated for it; and that if further work or referral seemed indicated he would be told so that this could be done by or through him. At no time did we usurp the role of the family physician. Rather, he enhanced the effectiveness of the whole evaluation by being in on it from the beginning. The confidence of the family was firmer and our end results better. The function of the school's evaluation of the problem was to give as complete a description as possible of the situation from its (the school's) point of view. The school is in a unique position to see problems which may not be at all evident in the home.

Last year, 22 of these "complicated" problems were recorded. These were far more often than not, behavior problems. One child seemed to be clearly headed for homosexuality. Another exposed himself in the school yard and used a broad spectrum of "filthy" words. A second grade boy tried to throw himself under passing automobiles on more than one occasion. An interesting kindergarten child always did just the opposite of what the teacher said. Serious physical problems included a girl with acute rheumatic fever, a child with seizures whose mother had kept it a secret, and a 14-year old girl who weighed 215 pounds.

After each person on the "team" had contributed his part to the study, the child was discussed at a pupil personnel conference held once a month. This meeting included the two principals, at times the Superintendent, nurse, doctor, psychologist, and reading teacher. The principals informed the teachers of findings and/or suggestions on individual children. An earnest attempt was made to see that each child reached as definitive care as possible. One hundred eleven situations, constituting 53 different children were discussed or re-discussed during the year at these conferences. Some had been or were being treated elsewhere and there was no need for the school to study the problem. Such defects, however, were reported to the group so that all the involved personnel would be aware of them. A complete report was obtained from whatever outside agency cared for the child and current reports were requested until the care was completed. Every case was followed to its conclusion. One was a child with bilateral cataracts treated at the National Institute of Neurologic Diseases and Blindness in Washington.

Once again, it should be emphasized, the concentration of effort was to see that each child received as definitive care as was available. Often this was given wholly within the school. For example, the psychologist in his discussions with the parents settled many problems.

More often, however—depressingly so—the parents proved to be woefully inadequate. Many did not even come to the school for conferences. Some balked at taking the child to the psychologic clinic as recommended. One mother frankly admitted she couldn't stand the child and wished the school would keep him all night, too.

In these situations it is impossible to accomplish much. But the school tried and at least felt effort was being expended on a needy object. It is impressive what a group of interested teachers and personnel can do to "fill in" a bit for such parents. For instance, the contrary kindergarten child mentioned above (incidentally, it was his mother who couldn't stand him) responded amazingly to the authority of the first grade and became responsive and responsible. His parents were totally unwilling to help. They said they did not have the "time" to take him to a psychologic clinic. School personnel realized that whatever (if anything) was done would have to be done by them. This time the results were gratifying.

Our health group was concentrating its time on pupils with legitimate problems who really needed help. The concerted opinion of the group was that more and better help was being offered to these problem children. Each individual on the "team" felt a satisfaction in his contribution because he *saw* results.

Improvements are always anticipated. Better teacher education as to early clues of behavior or physical problems is planned. Better psychologic clinics are always needed.

The cooperation between psychologist and physician has been very good. It is hoped the example will be accepted by other schools. Unity of effort obviously leads to better care.

In the county-wide program for improved school health, a competitive feeling between physicians and psychologists has become a major problem. Each feels the other is encroaching upon its domain. The study of any problem child needs the services of both. The physician, by a good physical examination, can assure to the best of his ability that no underlying physical disorder is involved. A brain tumor, a chronic infection, a growth problem —all these, and many more, should be kept in mind with "problem children." By scrupulously examining the child, the physician is giving a sounder basis to understanding of the problem and is giving the psychologist assurance that no organically dangerous disorder is present. In addition, he should contribute what he can, depending upon his training and interest, to the emotional aspect of the case. Then, by freely discussing the problem with the psychologist, the latter's work has as sound a beginning as possible. The psychologist is the busiest member of the group as far as being directly involved with the case is concerned. As most of the cases are behavioral, he must test and evaluate, and hold meetings with the families.

The cooperation of everyone in the Emerson School health program is the real secret of its success. This cooperation is essential to the success of any program. Keystone of the project is the sharing of opinions and knowledge in the conferences at this school; thus, each problem is carried to its most finite end.

SUMMARY

A school health system which has used the newer concepts of school health programs is described. The better utilization of time and efforts of all members of the health personnel is outlined and the more productive work accomplished is shown. It is hoped that these ideas may encourage other schools to adopt the newer approaches to school health.

10 Fairview Avenue

New Gauge of Psychomotor Skills

New technics for the early detection of disease and for evaluating a person's psychomotor ability may result from basic studies now being done with the Psychomet, an instrument designed at the Institute of Mental Health.

The Federal Aviation Agency, following the initial studies at NIMH, used the Psychomet to study the aging process in 160 civil air pilots and air traffic controllers. This revealed that psychomotor speed deficits may appear in some relatively young, healthy men and more markedly in stable cardiac cases.

Such observable changes may be helpful in predicting an individual's life span.

The Psychomet is an electronic apparatus that measures the speed and accuracy of a subject's responses to programmed stimuli. It was developed by Dr. James Birren and associates, at the Laboratory of Psychology.

The device records data simultaneously as the subject operates the panel before him which contains ten response keys and ten stimulus lights. The investigator can pair any light with any response button and present the ten stimulus lights to the subject in order.

The simplest test shows the numbers from one to ten in the lights and the subject is required to press the response keys as fast as he can from left to right, turning off the lights in order. This measures motor activity.

It has long been assumed that psychomotor speed tends to slow with age but little is known of the extent to which experience, education, habit or disease may have affected these processes. NIMH investigators feel that with the Psychomet it will be possible to explore more extensively the mechanisms of aging in the central nervous system, particularly the more complicated thought processes.

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Obstetrical Vacuum Extraction of the Vertex in Low and Outlet Stations*

The Malmstrom vacuum extractor may be modified by shortening the distance between cup and traction handle. This seems to be a safe and relatively non-traumatic substitute for forceps.

INCREASING interest in the vacuum extractor has recently become evident in the United States. Tricomi and associates[1] have cited their experience in 51 deliveries and we have reported its use in 60 cases.[2] Greenhill[3] lists most of the world literature on this subject through 1961. In this paper, we report on the modified Malmstrom vacuum extractor, applied to the vertex in the low and outlet stations and will comment on its use in these obstetrical situations.

METHOD

WE HAVE modified the Malmstrom instrument by shortening the distance from the cup to the traction handle from 12 inches to 4 inches. (See the figure.) Of the various sizes of metal cups furnished, we have used either the 40 or the 50 millimeter size in all cases. As soon as the occiput appears at the low or outlet station, the largest cup possible is applied to the vertex, the vacuum elevated to 6 kilograms per square centimeter. Then with suitable traction force, the delivery of the



Completion of extraction from low station.

*This paper is from the Department of Obstetrics and Gynecology at the Muhlenberg Hospital, Plainfield, N. J.

1. Tricomi, V., Amorosi, L. and Gottschalk, W.: American Journal of Obstetrics and Gynecology, 81:687 (July 1961).

2. Spritzer, T.: American Journal of Obstetrics and Gynecology, 83:307 (Feb. 1, 1962).

3. Greenhill, J. P.: 1961-2 Year Book of Obstetrics and Gynecology, Chicago 1961, Year Book Publishers, Pages 186-189.

head is slowly and deliberately completed with the patient under suitable anesthesia with or without episiotomy as indicated. (See the figure.) We have found the waiting time and intermittent traction usually recommended for the instrument unnecessary in these situations. As soon as the head is delivered, the vacuum is released, the instrument removed and the rest of the delivery completed as usual.

RESULTS

Of 135 cases in which we have used the vacuum extractor to date, 57 have been with the vertex in low or outlet stations for the following indications:

	Outlet Station	*Low Station*
52 Elective	12	40
4 Fetal distress	2	2
1 Uterine inertia	0	1

All of these deliveries were successfully completed within 10 minutes. There were no maternal or fetal complications in this group.

COMMENT

The vacuum extractor is a valuable instrument in a large variety of difficult obstetrical situations.[2] Its use in this series, limited to situations where the vertex is in the low or outlet station, appears, within our experience, to present unique advantages. It is an apparently safe method for accelerating the second stage of labor. Most obstetricians have encountered the situation where the vertex is at low or outlet station and completion of delivery is delayed by factors such as a non-cooperative patient, slowing of uterine contractions, or outlet dystocia. Utilization of possibly excessive fundal pressure and low or outlet forceps may be necessary to complete the delivery. The vacuum extractor in this situation permits the operator rapidly to obtain sufficient traction to complete the delivery without resorting to possibly traumatic fundal pressure or forceps. Further, the operator has full control of the delivery at all times so that precipitate expulsion of the presenting part can be avoided and laceration and extensions can be kept at a minimum. Delivery can be completed slowly and deliberately as desired in the best interests of baby and mother. The further advantage of non-encroachment on the diameters of the outlet as well as the minimizing of risk of carrying infection higher into the birth canal (as would be the case with outlet or low forceps) is eliminated. This method offers a safe and relatively atraumatic substitute for low or outlet forceps.

SUMMARY

Use of the shortened modified Malmstrom vacuum extractor in lieu of low or outlet forceps is described. After experience with 57 cases, we conclude that it is a safe, relatively atraumatic substitute for low or outlet forceps presenting certain unique advantages.

360 Mountain View Terrace (Dr. Spritzer)

The Integrity of the Drug Manufacturer

When a physician prescribes or a pharmacist dispenses a drug, each assumes legal responsibility for the purity, efficacy, potency, and freedom from unusual side-effects of the compound. Since neither the physician nor the pharmacist are capable of the detailed chemical and clinical analysis necessary to determine these factors they must rely on the integrity and character of the manufacturer—*Problems of Generic Prescribing*: D. F. Robinson, M.D., Oklahoma University Health Service.

Trustees' Meeting: February 18, 1962

At its February 18 meeting, actions taken by the Board of Trustees included the following:

The President reported that he had been invited to accept membership on a statewide sponsoring committee to help the Society for Crippled Children and Adults promote the elimination of architectural barriers to full use of public buildings by physically handicapped people. The project is planned along two lines: public education program to create awareness of the problem of architectural barriers and interest in eliminating them; and, consultation directly with individuals and groups in position to implement the "American Standards Specifications for Making Buildings and Facilities Accessible to, and Usable By, the Physically Handicapped." This long range public education and service effort is not a fund raising program.

Action: The president is asked to accept the invitation to serve as a member of the statewide sponsoring committee.

COMMENDATION OF EXECUTIVE OFFICER

In a letter to the President, a member of the Monmouth County Medical Society commended Mr. Nevin for "one of the most interesting 'listenable' talks I've heard in years on the subject 'The Medical Profession *vs.* Socialization' ", given before the county society's meeting in January. He suggested (and added that many others agreed) that Mr. Nevin appear on radio, television, and before the public at every opportunity in discussions and debates to bring out what Mr. Nevin calls the fight "for the life and character of the United States."

Mr. Nevin acknowledged with thanks the commendation and stated he will accept speaking engagements in the counties upon invitation when they fit in with his schedule, but that he could not disassociate himself completely from his regular duties to go on the circuit, unless directed by the Board to do so.

Action: The Board agreed that no action on the letter was required, and urged that the Executive Officer accept as many speaking engagements as he can, particularly invitations from the component societies.

CONTRIBUTION TO SETON HALL

Received from American Medical Association Education Research Foundation was a check in the amount of $7,487 for presentation to the Seton Hall College of Medicine by an officer of the Medical Society "with attendant publicity."

Action: The President or Chairman of the Board, or both, are asked to present the check at a Board meeting of the College; an announcement of this contribution to Seton Hall will be made in *Membership News Letter;* component societies are requested to reflect this news item in their local bulletins.

PREPAYMENT COVERAGE FOR SENIOR CITIZENS

The following statement, adopted by the AMA Board of Trustees on February 3, was read. This supplements its January endorsement of the National Blue Shield Senior Citizens Program:

The AMA Board of Trustees expressed its strong commendation of the private health insurance industry for its tremendous development of group and individual health insurance programs for senior citizens and other age groups. The AMA Board urges all physicians to accept an adjusted level of compensation for older persons of modest resources or low family income whether they are covered by private health insurance policies or Blue Shield plans. The AMA Board also urges physicians to consider such special compensation for services rendered to persons in this group whether they have health insurance coverage, a prepayment type policy, or pay directly for such expenses "out of pocket."

The Board of Trustees applauds those employers who are in increasing numbers covering their retired employees and making arrangements

for some kind of prepayment or health insurance plan for those about to retire.

The phenomenal development in recent years of prepayment plans and voluntary health insurance—especially among the aged—clearly reflects the preference of Americans for voluntary selection of financing mechanisms rather than for any compulsory government scheme.

MEDICO-LEGAL CONFERENCE

An invitation has been received to have representatives attend the conference for state and county attorneys and executive secretaires to be held in Chicago on May 18. Mr. Backes, legal counsel, has indicated his willingness to attend, and he has suggested to the AMA that the program include discussion on legislation for the incorporation of physicians for tax purposes. Mr. Nevin requested that, if possible, he *not* be assigned to attend this conference because of conflict with follow-up work on the annual meeting.

Action: The Executive Officer and/or legal counsel are authorized to attend the conference with expenses paid.

D.O.'S ON MEDICAL STAFFS

Mr. Nevin called attention to a recent release of the New Jersey Hospital Association supplied to administrators of member-hospitals concerning the admission of D.O.'s to hospital staffs.

In summary the release declares:

"... hospitals, both public and private, may establish reasonable rules to assure and enhance high professional standards for medical staff membership. A qualified M.D. should not be excluded merely because he is also a D.O. A public hospital may not withhold staff privileges arbitrarily. A private hospital may withhold staff privileges arbitrarily provided the bylaws and regulations are clear and are scrupulously followed. We can anticipate that our New Jersey courts will seize the opportunity to scrutinize whether there has been discrimination against a qualified M.D. merely because he is also a D.O. The presence of a qualified D.O. on the hospital staff would do much to eliminate the likelihood of a possible charge of unreasonable discrimination against osteopaths."

In reply to a question as to the definition of a private hospital, Mr. Backes stated that no decision has been rendered in New Jersey to define the distinction between private and public hospitals. In some states, institutions receiving federal funds have been treated as public hospitals. An ordinary hospital not supported by the government at any level is treated in New Jersey today as a private hospital. However, when an issue like this comes up there might be a change in that regard. Hospitals supported by campaign funds within the community are private hospitals. Hospitals receiving Hill-Burton funds are not necessarily in consequence public hospitals. However, in Arkansas and Missouri it was the courts' decision that hospitals receiving Hill-Burton funds are public hospitals.

AMPAC

The American Medical Political Action Committee is asking for the establishment of a separate state organization which would county attorneys and executive secretaries to have no direct connection with the national group, and which would be supported by separate contributions. The purposes of the national organization were approved by the AMA House of Delegates at the Denver session. It was the understanding of our representatives to the Denver meeting that efforts would be made to urge member-physicians to join the national organization. In a visit from representatives of the national organization to the Executive Offices, it is now made clear that establishment of a separate New Jersey organization is sought.

Dr. Allman has accepted the temporary chairmanship of AMPAC for New Jersey. It is his understanding that he would assist the national organization in promoting its membership campaign in this state. Since that time, however, the national group has suggested the establishment of a state committee on the same basis as the national committee, with a board of directors, a chairman for each congressional district, a chairman for each county or combination of counties, and a chairman for each hospital medical staff. In addition to the national organization membership dues from $10 to $99, the New Jersey committee would solicit members at additional dues of up to $25. The state funds would be used for office rental, supplies, services, and salaries, and also to make campaign contributions to individual candidates selected on a nonpartisan basis whose opinions coincide with those of the medical profession of New Jersey. No national funds will be available to New Jersey unless a national group wants the state committee to participate in an all-out political fight. AMPAC requests that this Board of Trustees announce

its endorsement of AMPAC, call its action to the attention of its individual members, and urge them to support and join AMPAC. The national group has inquired as to whether a membership campaign shou'd be conducted at local level or out of the national office in Chicago.

Action: The Board endorsed AMPAC, and encourages the members of the Medical Society—voluntarily and on an individual basis—to support AMPAC; this action of the Board and the purposes and goals of AMPAC will be publicized in the *Membership News Letter* and THE JOURNAL. However, it was the consensus of the Trustees that establishment of a State Committee should not be undertaken.

The national headquarters will be notified of the Board's action endorsing the program, and that solicitation of New Jersey physicians for membership in AMPAC be made by the national group.

PUBLIC HEALTH

A-13 would prohibit the discharge of pollutant materials into coastal waters. This bill is endorsed by the State Health Department. Our Council recommends that it be amended to include *all* waters of the State, not just costal waters.

Action: The proposed amendment is approved. The Council on Legislation will be notified that the Council on Public Health has gone on record as endorsing A-13 if and when the bill is amended to include *all* waters of this State.

The council has discussed enforcement of anti-litter ordinances. The State Health Department has anti-litter signs provided to municipalities without cost. The municipalities are responsible for posting the signs and enforcing the ordinance.

The Health Department has a model ordinance which the council will study with the thought that assistance of county medical societies might be enlisted to urge local action.

The council was informed by the State Health Department that one of the largest pollution problems is from houses. The Health Department is making an effort to introduce a bill which would permit the Department to set aside certain areas where only houses equipped with sewers can be erected. In some areas the sewage system utilized is completely inadequate.

Our Council on Public Health commends this type of legislation. They ask that our Council on Legislation be informed of the proposed legislation and of the action of the Council on Public Health thereon.

Action: The recommendations are approved.

SIGNATURE ON HOSPITAL RECORDS

In response to questions concerning signatures on hospital records as they apply to accreditation, the committee recommended that the following be sent to New Jersey hospital administrators, governing boards, and medical board presidents:

Physician are under the impression that they are required to sign hospital records (History, Physical, and Summary—*), not composed by themselves because this is a requirement of the Joint Commission on Accreditation of Hospitals. The attention of the Governing Board, Administrator, and President of the Medical Board of individual hospitals is called to the fact that the only rule of the Joint Commission applying to this subject is that all hospital records should be signed by a doctor of medicine licensed to practice in this State.

(*—"It is considered unnecessary to countersign progress notes or drug treatment orders written by house officers."

The following are pertinent excerpts from a letter of the Joint Commission on Accreditation of Hospitals:

"Under no circumstances have we ever nor do we require the chief of the department to authenticate the signature of any physician by the hospital to again authenticate the history and physical and summary.

"Authentication by the attending physician of the history and physical examination and the discharge summary written by the house officer is important for several reasons: It informs the young doctor of the accuracy of his workup and his diagnosis and, in case of disagreement between his observations and those of the attending physician, it affords an opportunity for discussion and for correction of the discrepancies. Such consultation benefits the patient, the house officer, and the attending physician. Second, the making of an accurate record is important to that patient's future care in the event of subsequent admissions to the hospital. Third, countersigning of an accurate history and physical examination and discharge summary indicates that the attending physician has read and accepted these at true. This may be added legal protection for the phy-

sician and the hospital. On the other hand, if the house officer's record is inaccurate, or if the discrepancy cannot be resolved, the attending physician should state in the record the facts as he sees them and should sign this entry; otherwise, he may be held responsible for errors committed by the house officer."

The chief of service and/or the attending physician assigns the patient to a responsible physician on his service who, in turn, is responsible for the completion and authentication of the pertinent records (History, Physical Examination, Progress Notes, and Summary), and signs the chart. Definitions from the Joint Commission are:

"1. Senior residents—defined as third, fourth or fifth year residents—need not have their histories, physicals and summaries authenticated if they are licensed physicians and the medical staff has allowed them this privilege.

"2. Senior residents, as defined above, may be given the right to authenticate histories, physicals and summaries written by externs, interns, first and second year residents, if the senior residents are licensed physicians and permission has been given to do this by vote of the medical staff."

Whenever a physician's name appears on any part of the records his chances of being subjected to legal liability are increased. Without in any way indicating that responsibility can be avoided by a failure to sign, it is important to realize that because the chances for liability are heightened by the signature, no physician should subscribe unless he is fully familiar with the records and matters to which he places his signature.

Action: The recommendation is approved, and the communication will be published in the *Membership News Letter*.

PROFESSIONAL LIABILITY RATES

The American Mutual Liability Insurance Company has agreed to eliminate the minimum requirements for limits in excess of 100/300, which will reflect reduction in rates for physicians in Territory I and for physicians and surgeons in Territory II. The committee recommended that the revised rates be approved.

Action: The revised rates are approved.

ENDORSEMENT FOR BROADER COVERAGE

The following announcement from the American Mutual Liability Insurance Company was directed to the Board's attention with the recommendation that the endorsement be approved, and that the announcement be published in the *Membership News Letter*:

This announcement is in accordance with the actions of most insurance companies writing malpractice insurance but actually is not necessary. The broadening of coverage by the other companies (but not by all) included libel, slander and defamation of character claims while acting as a member of an Accreditation Committee of a hospital or Society by a physician to whom hospital or society privileges are denied. American Mutual agreed in the beginning of this program to interpret its policy to cover such claims while acting on any authorized Medical Society or hospital committee, particularly membership and tissue committees.

The exclusions were eliminated, since they operated to creat many quesions of intent and were grounds for some companies to deny coverage. However, our program of coverage with American Mutual permits each county Medical Review and Advisory Committee to assist in determining application of coverage, and at no time was it expected that these exclusions would have applied except in cases of recognized criminal acts, complete intoxication, habitual and dangerous use of narcotics, and unethical written contract guaranteeing result of treatment.

The American Mutual Liability Insurance Company announces that, effective immediately, in order to provide its policyholders with broader coverage, it will interpret its outstanding Professional Liability policies, as protecting against (1) injury arising out of the performance of an alleged criminal act or caused by a person while under the influence of intoxicants or narcotics or (2) liability of others assumed by the insured under any contract or agreement, or to liability assumed by the insured under any agreement guaranteeing the result of any treatment.

It was previously agreed that the professional liability coverage protected the doctor while acting within the scope of his duties as a member of a duly authorized hospital committee, such as one passing upon the qualifications of doctors seeking admission to hospital staffs.

All of the above changes will appear in the policy upon next renewal. In the meantime, although no endorsement to this policy will be necessary, if any society member desires an endorsement setting forth these changes the company will be glad to issue same, upon request.

Action: The recommendation is approved.

COMMITTEE ON NURSING EDUCATION

The Board noted the report of the committee's meeting with representatives of the New Jersey Hospital Association on February 7, 1962. The committee reported that the next step in stimulating recruitment of nurses would be a "fact finding" meeting, called by the Medical Society committee, of representatives from the 35 hospital schools of nursing in New Jersey; and that following this meeting a joint meeting would be held with 10 or 12 "delegates" from the nursing schools, representatives of the Hospital Association, Nurses' Association, and State Department of Education.

Action: The report of the committee is approved.

MEDICARE PROGRAM

Supplemental Agreements 31030, 31031, and 3204 were reviewed.

No. 31030—To correct an omission in the renewal contract for 1960-61—authorizing the selection of HSP as subcontractor to the fiscal agent, MSA, for the administration of the Medicare Program.

Number 3204—To correct the same omission in the renewal contract for 1960-61.

The omission was an error on the part of ODMC, and the supplemental agreements are in accordance with the wording of the original contract. Both have been accepted and executed by the proper officials of MSA.

Action: The committee recommends that the Board authorize the execution of the agreements by the Medical Society. The Board approved this recommendation.

Number 31031—To establish a final claim rate for 1960-61 at $3.39 per claim as billed by MSA and including portion of MSA office salary costs.

This agreement has been accepted and executed by MSA; and the committee recommends that the Board authorize its execution by the proper officials of the Medical Society.

Action: The recommendation is approved.

Concerning the negotiations of a new Medicare contract for 1962-63, Dr. McCall suggested that in this negotiation (and discussion of administrative costs) representatives of the Society take a very active part and that this Board encourage the officers of MSA to be equally active and be completely familiar with the actual costs of administering the program and not leave the negotiations in the hands of the subcontractor.

Action: With the consent of the Board, Dr. Mulligan authorized the Special Committee on Medicare Program to represent the Society in the negotiations and directed that MSA be informed of the Board's attitude in the matter.

LEGISLATION

The individual items in the report of the actions of the Council on Legislation taken at its meeting on February 14, 1962, were considered. (These will be found on page 257 of this JOURNAL)

Action: Upon motions, the several recommendation of the council were approved.

Concerning S-142 (which is the same as S-150 of 1961), the council has heard from several specialty groups including the New Jersey Society of Pathologists and has received resolutions from three component societies and one specialty group recommending disapproval of this legislation. The position of the Society, last year and this year, is "No Action." The Board had previously determined to "send an official communication to all component societies and to all specialty groups, calling upon them not to take any position concerning pending legislation until they have checked and/or conferred with The Medical Society of New Jersey." The council suggested that the Board explain, on a confidential basis, the meaning of and the reasons for the Society's position of "No Action" concerning Senate 142 (Senate 150 of 1961).

Action: The Board approved the suggestion.

It was suggested that, inasmuch as MSP is opposed to S-142 (on the basis that Plan payment may be made only to participating physicians for services rendered), an alternate proposal for compensating the lay director of a bioanalytical laboratory might be considered. Possibly the physician could bill MSP for services rendered by the laboratory, and the physician would in turn, compensate the laboratory out of payment made to him by MSP. This is not "fee splitting" since the physician will show on his bill an item for service rendered by another person to him in the patient's interest and at his specific direction. A laboratory can perform service only at the

specific direction of a physician, and the laboratory reports to the physician, who then interprets the report. Thus, the physician's bill would include *all* professional services rendered by him personally and he, in turn, would remit the proper amount to the laboratory for technical services rendered to him in connection with the case.

Action: This aspect will be investigated with Medical-Surgical Plan

Representatives of the Council on Legislation met with Governor Hughes recently. There was free discussion on many matters of interest to the Society. The Governor is in favor of the King-Anderson Bill and of the social security approach to defray the costs of health services for those over 65. He also stated that following enactment of S-12 (which will implement the Kerr-Mills Act) the Medical Society, as a group giving service, would be consulted to assist in working out the State plan of operation.

Action: The report of the Council on Legislation was accepted.

MEMBERSHIP ELIGIBILITY

We have received a letter of information from the AMA directing attention to a report of its Board of Trustees noting the progress that has been made in eliminating race restrictions on membership in constituent medical associations and commending those societies which have moved forward in this area of human relations.

MUSEUM OF MEDICAL PROGRESS

The Board noted the resolution adopted by the AMA applauding the establishment of the Museum of Medical Progress at Prairie du Chien, Wisconsin, and encouraging medical societies and physicians everywhere to develop and continue an active interest in the collection and preservation of medical history as a living, vital means of expressing to the public the achievements of the medical profession in prolonging life and improving human welfare.

BLUE SHIELD PLAN FOR THE AGED

Received from MSP for the Board's information were copies of a policy letter received by MSP from the National Association of Blue Shield Plans outlining proposals for a national program and supplying copies of the national program contract.

Dr. Mulligan suggested that the Board authorize the appointment of a special committee to review this material and report back at the next meeting. With the approval of the Board, the following special committee was appointed:

Jesse McCall, M.D., Chairman
Jerome G. Kaufman, M.D.
Samuel J. Lloyd, M.D.
Ex-Officio: Chairman, Board of Trustees; President, President-Elect, Executive Officer.

MEDICAL QUACKERY

Dr. Allman and Mr. Nevin reported they had been called by the Science Editor of the *Newark Star Ledger* concerning medical quackery in New Jersey, and had been asked about possible legislation "which will prevent these quacks from practicing."

Action: The Board agreed that it would send a communication to Attorney General Sills, emphasizing the Society's interest in eliminating quackery in New Jersey and assuring him of its willingness to assist in evolving—and in supporting the passage of—any constructive legislation, properly and fairly drawn, for the protection of the public in this area.

Council on Legislation

In February 1962 our Council on Legislation took the actions indicated below on pending bills of medical interest. An asterisk* indicates that the 1962 bill is substantially similar to one introduced in 1961.

S-7 *Sandman*—To permit licensed physicians, sanitary inspectors, and executive officers of municipal boards of health to obtain a license as health officer without examination in certain cases. *Disapproval* . . . in adherence to the position taken by the House of Delegates of MSNJ

in 1961 and in support of the contention of the Commissioner of Health that such legislation would be a "retrogressive step in public health in New Jersey."

*S-12 *Sandman*—(Identical with A-27 and A-353)—To establish a program of medical assistance for the aged, assistance, and making provisions consistent with requirements for receiving federal matching funds. *Active Support*

*S-15 Dumont—To make certain diseases of volunteer firemen occupational diseases. *Disapproval* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

*S-26 *Fox*—To include within the definition of narcotic drugs any determined by the Health Commissioner to have addiction "liability" similar to morphine or cocaine. *Approval*

*S-27 *Fox*—To make possession by unauthorized persons of certain drugs without prescription a disorderly person's offense. *Approval*

S-32 *Ridolfi*—To authorize creation of professional service corporations. *Approval*

*S-36 *Fox*—To provide that no person, other than a pharmacist, shall sell any preparation containing codeine or any barbiturate to any person under the age of 21, except upon a written prescription of a physician, dentist, or veterinarian. *Disapproval* . . . until recommendations for broadening the prohibition are included.

*S-53 *Waddington*—To require as a condition precedent to a person's obtaining a motor vehicle license that such applicant consent to take breath or blood tests in suspected drunken driving cases. *Approval*

*S-61 *Connery*—To permit an injured employee to select the physician he wishes to treat him under Workmen's Compensation Act. *Approval*

S-120 *Stout*—To include "chiropractice physicians" under the law regulating chiropractors. *Active Opposition* . . . because it would give a title to chiropractors to which they have no proper claim; and would constitute an unwarranted extension of chiropractic.

S-123 *Farley*—To clarify the eligibility of certain dentists in relation to medical service plans. *Approval*

*S-142 *Stout*—To provide that services performed by a registered bioanalytic laboratory are within the scope of medical service plans. *No Action*

S-151 *Fox*—Companion bill to S-120. To define the practice of chiropractic as "a system of adjusting the articulations of the spinal column and related tissue by manipulation thereof." *Active Opposition* . . . because it is an unwarranted extension of the scope of chiropractic, and would give responsibility and privilege in areas for which chiropractors are not competent.

*SCR-2 *Dumont*—To reconstitute and continue the legislative commission to investigate the administration and rate schedule of the Hospital Service Plan of New Jersey. *No Action*

A-13 *Hiering, Maraziti*—To prohibit the discharge of pollutant matter or materials into coastal waters from any vessel afloat on said waters. *Approval*

*A-27 *Sarcone, Higgins, Rimm, Smith* — Identical with S-12 and A-353—*Active Support*

*A-40 *Smith, Rimm*—To provide for definitions of and standards for frozen dietary food. *Approval*

*A-99 *Hughes*—To change the definition of "narcotic drugs" to provide a more effective basis for the prevention of illegal use of narcotics. *Approval*

*A-113 *Stamler*—To provide that certain notices of hospital and medical liens may be filed in the county clerk's office within 90 days after the first day of treatment. *Approval*

*A-120 *Doren, Brigiani, Hughes*—To make any person who steals narcotics or breaks or enters any enclosure, any store room, ship, airplane, with intent to steal narcotics, guilty of a high misdemeanor. *Approval*

*A-176 *Meloni, Werner, Yost, Bigley*—To amend the act regulating nursing; reduces the age for professional nurse candidates from 20 to 18 years, and raises fees for examinations and registrations. *Approval*

*A-187 *Brady, Kijewski, Lynch, Meloni, Sweeney, Vohdin*—To establish the procedure for the Banking and Insurance Commissioner to disapprove rates of medical service corporations and for court review thereof. *Active Opposition* . . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unjustifiable denial of the fundamental right of the physician to set his own fee for professional services, thus threatening the operation of the Plan, in disregard of the best interests of the two million people of New Jersey who are its subscribers.

*A-203 *Brady, Kijewski, Lynch, Sweeney, Meloni, Vohdin*—Identical with S-61. *Approval*

*A-240 *Musto*—Identical with S-53. *Approval*

A-246 *Hauser*—To amend the procedure for granting religious exemptions from school immunization requirements. *Active Opposition.* In view of the recent outbreak of smallpox in England and other countries, legislation to excuse a teacher or pupil from being vaccinated against smallpox is untimely and dangerous to the public welfare.

*A-289 Sarcone—Identical with S-36. *Disapproval* . . . until recommendations for broadening the prohibition are included.

*A-292 *Sarcone*—To limit the time for bringing action at law by parents or guardians on behalf of minors under the age of 21 derived by reason of an injury to such minor. *Approval*

*A-293 *Sarcone*—Identical with S-27. *Approval.*

*A-321 *Hauser*—To allow any humane society to enforce certain provisions of laws relating to cruelty to animals. *Disapproval.* Existing laws which delegate this power to the New Jersey SPCA are adequate.

A-340 *Kay*—To prohibit the discharge of pollutant matter or materials into inland tidal waters and to regulate the operation of toilet facilities in vessels in said waters. *Approval*

*A-353 *Werner, Meloni, Hughes, Bigley, Yost, Wilson*—Identical with S-12 and A-27. *Active Support*

*A-383 *Hughes, Kordja, Higgins*—To regulate the practice of physical therapy or physiotherapy. *Active Opposition.* This is unnecessary and undesirable. The purpose of this legislation—to give

proper function under proper control—can be accomplished by simple amendment of the Medical Practice Act.

POSITIONS OF COUNTY SOCIETIES

The Council took cognizance of correspondence from the Camden, Cumberland, Passaic, and Somerset Component Societies, and from the Society of Surgeons of New Jersey—all of whom recorded opposition to S-150 (of 1961)—to permit inclusion of lay bioanalytic laboratories under Medical-Surgical Plan—and requested that The Medical Society of New Jersey oppose this measure. None of these groups consulted the State Society before taking this action. As recently as last July, the Council sent a special memorandum to component societies, requesting "that they not commit themselves concerning legislation until they have checked with The Medical Society of New Jersey, and that they not support legislation unless they have convincing proof that it is consonant with the welfare of the people and the true good of medical practice."

The Council strongly *recommends* that the Trustees send an official communication to all component societies and to specialty groups, calling upon them to take no positions concerning pending legislation until they have checked and/or conferred with The Medical Society of New Jersey.

Under the Bylaws, it is the responsibility and function of the Council on Legislation "to study and evaluate legislation—at state and national levels—proper to the interests of this Society." The Council then makes recommendations concerning positions on the legislation to the Board of Trustees. The positions approved by the Board then "become the official position of this Society." (Bylaws, Chapter IX, Section 5)

Only in this way can the members of The Medical Society of New Jersey be afforded unified and effective representation, with protection to the public welfare. For component societies or specialty groups to act independently and antagonistically is to destroy the efficacy of the Society's legislative mechanism and the Society's influence in the area of legislation. The Council on Legislation and the Board of Trustees make every painstaking effort to arrive at sound and constructive positions. The Society is prepared to explain and justify those positions for all properly interested parties.

CHIROPODY LAW

At the meeting of the Council on Legislation held November 1, 1961, chiropodist-representatives present formally requested that The Medical Society of New Jersey help to modify or clarify the present chiropody law, in any manner it sees fit, to enable chiropodists to treat the following:

(1) Osteomyelitis of the phalanges due to local infectious origin.
(2) Tendon transplantations in the metatarsal area of the great and small toe (involving toe function).
(3) Bone resections in metatarsal bones and phalanges.
(4) Simple uncomplicated fractures of the toes, requiring only supportive dressing.
(5) Dislocations of metatarsal-phalangeal joints.
(6) Treatment of congenital deformities of the toes and forefoot excluding clubfoot, et cetera (Medical Society to enumerate).

By action of the Board of Trustees at its meeting on November 19, 1961, the Council on Legislation is authorized to explore further the possibilities of thus modifying the chiropody law, in light of this new request.

On February 18, 1962 the Council on Legislation approved amendments to the chiropody act to permit extension of the definition of chiropody to include:

(1) Simple uncomplicated fractures of toes, requiring only supportive dressing.
(2) Dislocations of inter-phalangeal joints.

BEADLESTON ACT

The Council unanimously approved the amendment to the 1959 Beadleston Act—proposed by the Society's Special Committee on Child Health (through the Council on Public Health and approved by the Board of Trustees). The text follows:

1. Section 2 of the act of which this act is amendatory is amended to read as follows:

2. The Commissioner of Education shall appoint for each county department of child study or, with the approval of the State Board of Education, for one or more county departments of child study, which shall be charged with the duty of performing the services required to be performed at the county level under this act, a supervisor, whose duties shall include the co-ordination of the special education services in the county, and he may appoint, upon a full or part-time basis, such additional per-

sonnel, constituting a child study team, as he deems necessary to perform such services.

The members of each child study team shall include, but need not be limited to, *a school physician*, a school psychologist, a school social worker, a remedial specialist and a psychiatrist, and the Commissioner of Education shall fix their compensation with the approval of the State Board of Education.

The county superintendent of schools of the county or the county superintendents of schools, of the counties served by one child study team, jointly, shall, with the approval of the Commissioner of Education, designate a member of the child study team to serve as chairman and in event that they cannot agree the chairman shall be designated by the Commissioner of Education.

2. Section 3 of the act of which this act is amendatory is amended to read as follows:

3. Each county child study team shall function in consultation with the local boards of education in the county or the local boards of education in the counties served by it in the fields pertaining to:

a. diagnosis of children needing special educational services,
b. approval of public programs of mental health,
c. supervision of public school mental health programs,
d. reporting and referral of children with mental health problems, of such severity as to indicate the necessity of medical or (psychological) *psychiatric* treatment, to the (appropriate agency) *family and appropriate family physician and/or consulting psychiatrist* for such purpose,
e. social case work and psychologic evaluation,
f. remedial instruction,
g. cooperative action with other State and county departments and lay professional organizations, and
h. additional responsibilities as determined by the Commissioner of Education and the approval of the State Board of Education.

SCHOOL EXAMINATION LAW

The Council unanimously approved the amendments proposed by Dr. Geoffrey Esty, Special Consultant in School Health Education, to S-66 of 1961 (school examination law, introduced by The Medical Society of New Jersey).

It is the purpose of this bill, by permissive legislation, to authorize the school medical inspector to accept *evidence of a satisfactorily performed* physical examination made upon a pupil by his treating physician, in lieu of the examination which, under the present statute, the school medical examiner or the school nurse is directed to make. *This bill does not curtail the continued legal responsibility of the school medical inspector for the determination of the physical status of every pupil.*

Here is the text of the changed paragraph. The italicized phrases are the ones that would be added:

18:14-57. The medical inspector, or the nurse under the immediate direction of the medical inspector, shall examine every pupil to learn whether any physical defect exists, or in lieu thereof *the medical inspector may accept the report of such an examination by a duly licensed physician of this State*, and shall keep a record from year to year of such pupil's growth and development, which record shall be the property of the board of education, and shall be delivered by the medical inspector or nurse to his successor in office.

A pupil who presents a statement signed by his parent or guardian that a medical examination interferes with the free exercise of his religious beliefs shall be examined only to the extent as may be necessary to determine whether he is ill or infected with a communicable disease or to determine his fitness to participate in the health, safety and physical education course as required by section 18:14-93 of the Revised Statutes.

Reporting Maternal Deaths

In some areas, maternal deaths are not being reported because they occur in connection with patients who are re-admitted to hospitals for some condition following delivery.

The State Department of Health is requested to notify responsible agents in each hospital that all deaths following a recent pregnancy (up to six weeks) be reported as maternal deaths and special notation be made on the death certificate as to date of delivery. This is published to bring this recommendation to the attention of all physicians.

Medical Officers on CD Staffs

Does your city or town have a physician on the municipal Civil Defense staff? If not, this is a serious omission. You never know when CD will have to go into swift action. And when it does, medical authority must be available on short notice. Our CD Medical Coordinator urges that every municipal Civil Defense organization appoint a medical officer and a deputy officer soon. If volunteers are bashful about coming forth, let the County Medical Society designate two for each municipality.

Obituaries • • •

DR. SIDNEY D. BECKER

A busy civic and medical career came to a close on March 18, with the death on that day of Dr. Sidney D. Becker, at the age of 56. Born in Newark, he was graduated from Columbia University in 1924 with a pharmacy degree. He then returned to college, majored in chemistry and biology and earned a B.S. degree in 1930, and then spent four years at Bellevue, receiving his M.D. in 1931. Dr. Becker interned at the Martland Medical Center in Newark and then entered private practice in his native city. Subsequently, he moved his office to Keyport. He was one of the pioneers in the American Academy of General Practice and was president of the New Jersey unit of that Academy. He had also served as chairman of the GP section of the Northern New Jersey Academy of Medicine. Dr. Becker was active in the affairs of the New Jersey Diabetes Association. In 1956, he was president of our Middlesex County Medical Society. For services to the federal government he received citations from President Roosevelt and again from President Eisenhower.

DR. EUGENE G. HERBENER

Born in 1880, Dr. Eugene Garfield Herbener died on March 30, 1962. After receiving his M.D. at Bellevue in 1908, he did graduate work in the then young specialty of anesthesiology. Dr. Herbener was one of the first to devote much time to this field, and eventually became chief of anesthesiology at the Paul Kimball Hospital in Lakewood. He was also active in public health affairs in Ocean County, and had a tour of duty as president of the Health Association of that county. In 1958 he received the Golden Merit Award of The Medical Society of New Jersey. In addition to an extensive general practice, and service in anesthesiology, Dr. Herbener was a medical examiner for the New Jersey Central Railroad.

DR. WALTER A. RULLMAN

Monmouth County lost one of its seniors on March 19 with the death that day of Dr. Walter Ames Rullman. Born in Maryland in 1885, he was graduated in 1911 from the medical school of the University of Pennsylvania. He came to Monmouth County to intern at Monmouth Memorial, and liked our state so much he never again left us. In 1913 he opened his office in Red Bank; and he served the people of that area for almost half a century thereafter. He had a term as president of the Monmouth County Medical Society. He served in the medical corps of our Army in 1917 and 1918. He was active in civic and athletic affairs, particularly in ice-boating where he was, for many years, a champion. At first a family doctor in every sense of the word, Dr. Rullman soon limited himself to surgery and eventually became director of surgery at Riverview Hospital as well as senior surgeon at Monmouth Medical Center and surgical consultant at the Fitkin Memorial.

DR. JOSEPH H. SCOTT

Dr. Joseph Hurlong Scott, a well-known New Jersey practitioner, died of a coronary attack on April 4. A 1923 graduate of the medical school of the University of Michigan, Dr. Scott practiced for a quarter of a century in Atlantic City. He was a family doctor, and in addition served variously as fire surgeon and police surgeon there. He served with the cavalry in World War I, and was on a rationing board during World War II. Dr. Scott was born in Sumter, South Carolina in 1896. In 1952 he moved his office to Newark.

DR. MAX SILVERSTEIN

One of Monmouth County's civic and medical leaders died on March 23. He was Dr. Max Silverstein. Born in New York in 1892, Dr. Silverstein received his M.D. in 1917 at the University of Maryland. He interned in Baltimore and then returned to Monmouth County (where he had been brought up) to practice. He was active in Asbury Park civic affairs and was a city councilman there in 1933, 1934 and 1935. Especially interested in otology and laryngology, Dr. Silverstein served the Monmouth Medical Center in that capacity. However, he always considered himself, proudly, a general practitioner and a true family doctor.

DR. CHARLES C. TERRY

Dr. Charles Chapin Terry, Medical Director of the Hudson County Welfare institution, died suddenly on March 8. Born in Indiana in 1897, he entered the Army in 1917 and was a pioneer pilot —one of the few surviving World War I pilots. Then, in 1923 he was accepted at the medical school of the University of Michigan from which he received his M.D. in 1927. Always interested in military affairs, he switched from the Army to the Navy and reached the grade of captain in the Navy Medical Corps during World War II. Dr. Terry was an early diplomate in surgery, having been certified by the American Board in 1951. Later he became medical director of the Hudson County Welfare Institution, in which position he was serving at the time of his death.

DR. ANTHONY VIRGILIO

Born in Orange in 1906, Anthony Virgilio received his M.D. from Georgetown in 1934. He died on March 30, at the untimely age of 56. Dr. Virgilio served as a captain in the U.S. Army Medical Corps in World War II. He also had several tours of duty as Orange City Physician. Dr. Virgilio was a general practitioner on the staff of St. Mary's Hospital in Orange.

DR. MICHAEL VINCIGUERRA

A past-president of the Union County Medical Society, and one of our state's pioneers in psychiatry and neurology, Dr. Michael Vinciguerra died on March 26. Dr. Vinciguerra established the psychiatric service at Elizabeth General Hospital, one of the first and most successful general hospital psychiatric units in New Jersey. Born in Italy in 1885, he came to the United States in 1895 and received his M.D. at the University of Maryland in 1912. After interning at the Elizabeth General Hospital, he enrolled in the U. S. Army Medical Corps and saw service during World War I. He then returned to Elizabeth, specializing in psychiatry and neurology. Dr. Vinciguerra was active in hospital, civic and medical society affairs. He served as president of the Elizabeth Board of Health. He was a diplomate of the American Board of Psychiary and Neurology and was consultant neurologist or psychiatrist at many hospitals in the Union County area.

Professional Liability Coverage

Eighteen months ago, most of our county medical societies indicated complete endorsement of the new professional liability insurance program of The Medical Society of New Jersey. For this program to reach its maximum effectiveness, 80 per cent of all physicians in each community should be insured with the same carrier. The higher the percentage, the more effective will be the control with better results. Coverage has now been improved to eliminate exclusions pertaining to the use of alcohol or narcotics, criminal acts and alleged contract. It was also agreed to endorse current policies, if requested, to cover claims of libel, slander or defamation of character arising from membership on an accreditation committee of a hospital or medical society. This policy will be interpreted to cover such claims.

This program is designed for the protection of the insured members. So there will be no question, the company will issue new policies upon renewal, effective November 1, 1962, with these changes. The new policy will clearly state the interpretation that claims for libel, slander or defamation of character arising out of acts in the practice of the medical profession will be covered. This does not limit such claims to accreditation committees and definitely covers tissue committees or other alleged actions or activities. To my knowledge, no other insurance company gives this complete protection.

At the request of the Society, coverage is now available to a maximum of $500,000 per claim and $1,500,000 aggregate and should any physician wish to increase his limits of coverage, he should get in touch with Mr. J. A. Britton at ORange 3-2575 or write to the American Mutual Liability Company at 68 South Harrison Street, East Orange.

County Society Reports

Middlesex

A special business meeting of the *Middlesex County Medical Society* was called to order by the president, Dr. Thomas P. McLaughlin, at the Roosevelt Hospital, Metuchen, on Wednesday evening, March 21.

Dr. B. F. Slobodien, chairman of the Judicial-Medical Ethics Committee, reported that he had not received approval from the Credentials Committee of The Medical Society of New Jersey on the applications of those awaiting membership; therefore, no vote could be taken. Concern was expressed about this delay. It was reported that it has created some hardship for doctors waiting appointments to hospital staffs. However, since this ruling was established to prevent unqualified applicants from obtaining membership in the Society, it was felt that we could not give these doctors even temporary membership. Dr. McLaughlin then read a letter from Vincent Reuther, Executive Vice-President of the Community Hospital Group, Inc. This group is seeking endorsement for their plans to sponsor a new 200-bed hospital in the Menlo Park area. It was felt that until more information could be obtained we could not offer our endorsement.

Dr. Sidney Becker died on March 19, 1962 and a letter of condolence was sent to his family. Dr. McLaughlin lead the members in a minute of silent prayer.

The panel of officer candidates for the coming year, proposed by the Nominating Committee, was presented by Dr. Calvin. The suggestions were:

President, Dr. Ralph E. Siegel, Perth Amboy; *Vice-President*, Dr. R. G. Matflerd, New Brunswick; *Secretary*, Dr. Albert S. Basri, Colonia; *Treasurer*, Dr. Eugene J. Tyrrell, Perth Amboy, *Reporter*, Dr. Eugene L. Childers, Nixon. *Trustees* would be Doctors Thomas F. McLaughlin, chairman; Charles H. Calvin, Stanley A. Gadek, Charles Gandek, Gerard R. Gessner, George J. Kohut, William G. Kuhn, A. Marshall Smith, Sr., John A. Smith, and B. F. Slobodien.

Judicial-Medical Ethics Committee: Doctors Benjamin F. Slobodien, Chairman; Donald T. Akey, George T. Henderson, S. David Miller and W. Edgar Sherman.

Delegates: Doctors Sidney D. Becker, Charles H. Calvin, Albert Schwartz, Gerard R. Gessner, Sol Gurshman, Howard D. Slobodien, Ralph Siegel, A. J. Barbano and Charles Gandek. *Alternates* nominated were Doctors Cyril I. Hutner, Louis A. Perillo, Edward Jasionowski, Morton M. Klein, Joseph T. Lang, Eugene L. Childers, Gerard J. Aitken, Jr., Harold B. Fein and Victor Boogdanian.

Our Society unanimously approved a public relations medical sports program, to be given at the Rutgers gymnasium on April 28, 1962. This will be a symposium by members of our Society on athletic injuries, protection, and treatment.

The special meeting was then adjourned, and the members joined our friends—the pharmacists—for a pleasant meal and entertainment at Oak Hills Manor.

EUGENE L. CHILDERS, M.D.

Reporter

Salem

The March 13 meeting of the *Salem County Medical Society* was called to order at 4:45 p.m. by the President, Dr. William Sprout, at Richman's in Sharptown. Thirty-one members participated in this combination business-dinner meeting.

Dr. B. Norton, chairman of the Nominating Committee, presented its recommendations for 1962-1963:

President: Wilbert Staub, M.D.; Vice-President: Philip Boyer, M.D.; Secretary: George Reichwein, M.D.; Treasurer: Donald McClean, M.D.; Reporter: John Dooley, M.D.

Delegates to the State Society: Harry Fullerton, M.D., three years; Frank Xhilone, M.D., Alternate; Spencer Davidson, M.D., Nominating Delegate; Harry Fullerton, M.D., Alternate.

Nominations from the floor will be considered at the April meeting, with the election of officers to be held then.

Dr. Joseph Fishbein gave the report of the Annual Dinner Committee. He announced that, with the approval of the membership, it would be held at the Sakhna Country Club in Penns Grove on May 19, 1962. This was unanimously approved.

Dr. Isadore Lipkin, local Diabetic Week chairman, reported that 544 urine tests for sugar were done during the drive. Of these 21 were positive, 19 being known diabetics and 2 newly discovered. The meeting was adjourned at 5:39 p.m.

JOHN T. DOOLEY, M.D.

Reporter

Union

The annual meeting of the *Union County Medical Society* was held on March 15 in Kenilworth at the White Laboratories. Mr. Richard I. Nevin, Executive Officer of The Medical Society of New

Jersey, brought greetings from the president of the Society, Dr. Ralph Buchanan. He spoke briefly on matters of importance to the members.

Resolutions were adopted, noting with sorrow the recent passing of Drs. William A. Cogger, Willis B. Day and Daniel C. Hackett, all of whom had been members of the county society and of the Staff at Muhlenberg Hospital. A moment of silence was observed.

Admitted to active membership was Dr. Richard Newman of Rahway; to associate membership, Drs. Rudolph C. Dangelmajer, Summit; Morton Farber, Linden; and Joseph Klinger, Elizabeth.

Dr. Henry J. Konzelmann, the retiring president, gave an address touching upon the responsibility of the physician to the patient, the community and the nation. He was presented with a plaque which expressed appreciation for his services to the Society during his term of office.

The following were elected as officers of the Union County Medical Society for the ensuing year: President, Dr. Charles W. Boozan, Elizabeth; President-elect, Dr. Joseph M. Gannon, Plainfield; First Vice-President, Dr. Arthur T. Willitts, Summit; Second Vice-President, Dr. Elbert H. Pogue, Elizabeth; Secretary, Dr. Roy T. Forsberg, Elizabeth; Treasurer, Dr. Henri E. Abel, Elizabeth; Reporter, Dr. George L. Erdman, Summit.

GEORGE L. ERDMAN, M.D.

Reporter

Disability Insurance Reports

The following letter was received by the Executive Officer of The Medical Society of New Jersey from the State Division of Employment Security. It is a plea for your cooperation in the relatively simple paper work which is needed to provide your patients with benefits to which they are legally entitled. The letter follows:

R.S. 43:21-39, *Limitation of Benefits,* states in in part ***no benefits shall be payable to any person: (b) for any period during which the claimant is not under the care of a legally licensed physician." All Private Plans have this provision likewise.

During 1961, an estimated $47,000,000 in cash temporary disability benefits was paid out to claimants. *Almost every cent of this disbursement was upon the certification of your membership.* The role of the physician is essential under the Statute in paying benefits under this program. We must give full credit to the bulk of your membership for its willing acceptance of our requirements. It is only with the relatively few physicians that we have a problem; which we hope will be cleared up with your cooperation.

This problem falls into three general areas:

A. The first is timely filing. The Statute provides written notice and proof of disability be furnished not later than thirty days after the commencement of the period of disability. We have the area wherein patients present to the doctor the State claim form, or an insurer's claim form, and the doctor holds this form for a lengthy period before sending it on to the State, or returning it to the patient so that the patient can send the claim form. Under such conditions the claimant may lose all or part of the benefits.

B. The second area is wherein the physician fails to respond to any communications from the State or the Private Plan. As the program is administered almost entirely by mail, *we are absolutely dependent upon the cooperation of the physician.*

C. When pieces of paper have to be handled and re-handled without a decision being reached this becomes a costly matter in terms of time wasted and dollars spent fruitlessly. Any businessman, and this includes physicians, recognizes the justice of this statement immediately. In the compassionate area we have a law to provide weekly cash benefits to people who are ill, injured and unable to work. The assumption is that they are, or can be, without other income; and this program is designed to prevent need. *If weeks or months lag on before payments can be made, there may be undue suffering* and need, and the purpose of the program is to an extent nullified.

Of course, we can also point out that the physician may have a personal interest in the proper prompt payment of these cash disability benefits to his patients. There is the presumption that, if these patients have income, they are in a better position to meet their bills; the physicians' included.

The type of information required from the physician is simple and brief. The entries can be made speedily by either the doctor, or his assistants and signed by the doctor. The matter is then closed as far as he is concerned. We would urge that the doctor do this at the time when the patient presents the forms, and that they be handed right back to the patient to take care of his own interest from then on. In cases where there must be correspondence between the physician and the agency paying benefits (State, employer, union, or insurer) all concerned would appreciate a prompt completion and transmittal of the information.

Very truly yours,

B. N. SHEFF,
Chief of Private Plan
Disability Benefits

Announcements

Consultants Wanted: All Specialties

The Disability Determinations Service of the New Jersey Rehabilitation Commission is interested in expanding its panel of physicians in most of the specialties. This is the agency which makes determinations of disability on applicants who file for benefits under the disability provisions of the Social Security Act.

Physicians on this panel receive referrals from the Disability Determinations Service for consultations to evaluate the working ability of the applicant.

Disability Determinations Service has had a panel of physicians since 1956. The Agency reports that these physicians have given excellent medical reports, and have cooperated with the Agency in a highly satisfactorily manner.

It is now the desire of the Agency to bring the panel up to date and to add names of physicians in accordance with their specialty. Fees allowed for the consultative examinations are considered reasonable and are in accordance with the fee schedule for the New Jersey Rehabilitation Commission.

Physicians interested in becoming members of this panel should write to Mr. Benjamin Steinlight, Assistant Director, Room 500, Disability Determinations Service, 309 Washington Street, Newark 2, New Jersey.

Seminar on Rheumatoid Disease

On Wednesday afternoon and evening, May 23, the Academy of Medicine will sponsor a symposium on rheumatoid disease at the Essex House, Lincoln Park, Newark. A star-studded faculty has been assembled from the four corners of the country, to conduct a panel on the epidemiology and clinical aspects of rheumatoid diseases. There will be a dinner at 6 p.m. followed by an address by Professor Paul Weiss of the Rockefeller Institute. Dr. Weiss will discuss tissue architecture. You are welcome to attend the lectures. For dinner reservations, write to Dr. Milton Shoshkes at 505 Elizabeth Avenue, Newark.

Graduate Study in the Adirondacks

The Trudeau School will hold its forty-seventh session in Saranac Lake, N. Y., June 4 to June 22, 1962. This annual graduate course for physicians provides top-level instruction in chest diseases. Tuition is $100 for a three weeks' session. Attendance at the Trudeau School carries with it a thorough review for specialization in pulmonary diseases or for work in public health involving tuberculosis.

Half of the time is devoted to tuberculosis and the other half divided among such subjects as silicosis, pulmonary fibrosis, emphysema, fungus infection, sarcoidosis, pneumonias and intrathoracic tumors.

Inquiries should be addressed to the Trudeau School, Box 670, Saranac Lake, New York.

Calling All Medical Women

Women physicians attending the AMA meeting in Chicago next month are invited to attend a special "brunch" as guests of the American Medical Women's Association on Sunday morning, June 24, at Chicago's Essex Inn, at 11:00. A lively discussion is planned as well as an attractive combination breakfast and luncheon. If you can attend, write to American Medical Women's Association at 1790 Broadway, New York 19, N. Y.

Courses in Chest Diseases

The American College of Chest Physicians announces the following courses:

Cardiac and Pulmonary Problems in Children—Chicago, July 23-27.

Recent Advances in Heart and Lung Diseases—Philadelphia, Sept. 17-21.

Cardiopulmonary Physiology—Chicago, October 22-26.

Treatment of Heart and Lung Diseases—New York City, November 12-16.

Occupational Diseases Affecting Heart and Lungs — Detroit, December 3-7.

Tuition is $100 for any course, with a lower rate to ACCP members. For additional information, write to American College of Chest Physicians at 112 East Chestnut Street, Chicago, Illinois.

Cardiac Home-Hospital Expends Services

The Newark U. O. T. S. Home-Hospital in East Orange, N. J., has just expanded its program of in-patient care and rehabilitation to include all children between the age of 3½ and 12 years suffering from active heart disorders. If appropriate, children will enter the Home-Hospital where they are nursed to convalescence and then to almost normal health before discharge.

The Home-Hospital is a non-profit, nonsectarian rehabilitation center equipped and staffed to provide complete medical, dental and psychologic care. Dr. Jerome G. Kaufman is Medical Director of the Home. Although hospital routine is maintained, the institution radiates a home-like atmosphere developed by nursing staff and volunteers. School instruction, at bedside and in classroom, is provided by the Newark Board of Education.

The Home-Hospital is inspected and licensed by the New Jersey Department of Institutions and Agencies. Operating costs are met in part by the Home-Hospital's sponsors (United Order of True Sisters, Inc., Fidelity-Hulda No. 26); various Community Chest Funds; state and local health commissions; county Heart Associations; and by contributions from foundations, organizations and individuals.

AMA Establishes Medicine-Religion Department

"How to provide better health care for the whole man is the chief concern of our new department." This is the Rev. Dr. Paul B. McCleave's nutshell definition of the AMA's new Department of Medicine and Religion. Its goal is encouraging closer relationships between physicians and clergymen.

"Too often today," Dr. McCleave says, "we forget the patient and parishoner's needs in total health—physical, mental and spiritual. The three are not separable." Dr. McCleave adds that the best patient care is achieved when physicians and clergymen share mutual concern for the patient and when each contributes his special talents.

Terminal illness is an illustration of an area in which the clergy can be of particular help to physicians.

The new department will foster close physician-clergy relationships through programs carried out on the local medical society level and tailored to fit local needs.

Dr. McCleave is currently working with medical society leaders and physicians in states where pilot programs will be launched. These states are: Arizona, Georgia, Iowa, Maryland, Montana, New York, Ohio, Texas and Utah. The new department will work through state, county and local medical societies as a servicing and counseling unit of the AMA. It will seek, on the state level, leadership teams of physicians and clergymen, including psychiatrists and hospital chaplains. The teams will present programs to medical and religious gatherings showing how teamwork is utilized for better patient care.

Dr. McCleave lists two other key functions of his department:

(1) The encouragement of closer relations between pastors and physician members of their churches to discuss health and spiritual programs.

(2) The preparation of articles and editorials for the medical and religious press. Early articles will seek to define the patient's total health needs and point up the philosophy of "the whole man." The department also plans close liaison with hospital chaplains, mental health authorities and pastoral clinical training centers. Similar liaison is planned in the area of medical, theological and nursing school curriculums.

Dr. McCleave until a short time ago was pastor of the First Presbyterian Church in Bozeman, Montana. He has served as president of Emporia College; spent 44 months as a Navy chaplain, 27 of them overseas; and has pursued graduate study in Geneva, Switzerland. His work in Geneva centered around the ecumenical church, a study of all branches of the Christian faith.

Letters to The Journal • • •

Child Safety: Is This a Doctor's Responsibility?

Dear Doctor:

Recognizing that accidents in children already account for more deaths (20,000) than do the other four leading illnesses (cancer—including leukemia, congenital deformities, tuberculosis, and poliomyelitis), The Medical Society of New Jersey—through its Child Health Committee—sponsored a Symposium on Child Safety in Newark on April 7.

The participants included three pediatricians, and representatives of the Red Cross, New Jersey State Safety Council, State Department of Education, Boy Scouts, New Jersey Congress of Parents and Teachers, and the Boys' Clubs.

The Medical Society sent out 500 invitations and releases to daily newspapers and wire services as well as spot announcements to New Jersey radio stations.

The Medical Society made the necessary arrangements with Governor Hughes for him to proclaim the week of April 1 to 7 as "Child Safety Week," with its incidental newspaper publicity.

Despite all the careful planning and publicity, only eleven people appeared at the symposium.

It would certainly appear that child safety must be the concern of somebody else.

ROBERT E. JENNINGS, M.D.

Are Pathologists Exploited?

Sir:

In your March 1962 JOURNAL, Dr. Rathmell makes an impassioned and necessary plea for support in meeting the costs of postmortem examinations. There is one facet of postmortem work that is never discussed: the out-and-out exploitation of the pathologist and the voluntary hospital in the small community in connection with medico-legal autopsies. I write from personal experience in both New Jersey and in New York. As long as we tolerate medical examiner's work being slipped into the hospital budget, we cannot reasonably expect the local government to give any support to postmortem work in general.

It is common practice for the medical examiner to instruct the hospital to obtain a consent for autopsy from the next-of-kin in case of a death occurring under circumstances which make it *mandatory* for him to investigate that death. The autopsy thus becomes a "hospital post," and the local government is spared the payment of a fee. Before any attempt is made to obtain general support for postmortem examinations, we should insist that this kind of abuse cease. If it does nothing else, it will establish the immediate value of competent postmortem examinations to the community in deaths occurring under circumstances requiring investigation, which is required by laws enacted by representatives of the public which will have to foot the bill.

From a purely financial standpoint this will educate the public with respect to postmortem studies and it will reduce the direct subsidy for postmortem studies in general. If the cost of medico-legal autopsies is not clearly separated from those which do not come under the jurisdiction of the medical examiner, we shall be forever lost in a welter of appropriations whose specific purpose is befogged. Let us first insist that the postmortem that is the reponsibility of the public be wholly paid for by the public. If more help is needed for work which is of unquestioned value to the public, but not required by law, we should make a separate application for help. Let us not confuse medical study with law enforcement.

I have deliberately avoided any discussion of the dangers of the present small-town practice among medical examiners of foisting their work off on local pathologists. The dangers of leaving the decision of permitting the postmortem in such cases to the next-of-kin are too well known to be discussed here. It might well be an appropriate subject for discussion in a monograph on medical jurisprudence.

Yours truly,

PAUL deR. KOLISCH, M.D.
North Tonawanda, N. Y.

Humidifier vs. Vaporizer

Sir:

Dr. Haase and Noguera wrote an excellent article in the March JOURNAL on a frequently neglected subject—the great American symptom—postnasal drip.

For overcoming the dryness which is so often the cause, they say, "Treatment of this phase can be best approached by having a vaporizer in the room in which the person sleeps."

A humidifier would be better than a vaporizer. Humidifiers have come down in price and an adequate one can now be purchased for about $20.

A vaporizer heats water and makes steam. A humidifier circulates water and makes a "cold" vapor.

Sincerely yours,

FRANK L. ROSEN, M.D.

Psychosomatic Profile • • •

From time to time, THE JOURNAL will publish in this space an item on psychosomatics of interest and importance to all medical practitioners. Contributions are invited and should not exceed 500 words each.

The Uncommon Cold

It used to be that a library card, a few textbooks and just enough German to read the original arbeit insured a physician comprehensive and exclusive knowledge of a given medical problem. Not now. Despite the relative privacy of refresher courses in Vegas and Curachi, the doctor new shares with the public the neo-classic *Materia Medica* comprised of that column in the Sunday New York *Times*, alternate issues of the *Readers Digest* and the weekly *Ben Casey* live clinics. A little investigation has convinced me that there is literally "no hiding place," not even on the erstwhile sanctuary of non-scientific fantasy—the Broadway musical stage. Take the mundane matter of "common colds."

What might be considered the modern era of investigation in this field began in 1950 with the Common Cold Research Unit in England. Here control groups, living in isolated vacation villages long enough to insure the absence of extrinsic sources of infection, received intranasal doses of active cold virus and were then studied in variable situations. It was demonstrated, for instance, that volunteers, subjected thereafter to hunger, lack of sleep, nocturnal alarums and chilling exposures showed no higher incidence of upper respiratory infections than a control team enjoying every creature comfort and protection. In another test only one of 19 normal subjects exposed to sneezes and coughs caught a cold. Obviously something besides the mere presence of virus had to be involved.

There was, of course, the matter of "resistance." But this was too vague a concept to satisfy serious investigators for very long. Other possible components emerged: immunologic status, integrity of interstitial tissues, hematologic and endocrine adequacy, nutritional parameters, phagocytosis, and so on. And there were many, too, who felt, like G. N. Raines, that "the direct relationship between emotions and respiration has long been evidenced in the poetry, language, art and culture of our society. The expression 'hold your breath' had meaning even to children long before scientific investigation revealed that the height of attention is accompanied by the very least in respiration. When you read or hear, 'I caught my breath,' you have no doubt as to the anxious fear present in the speaker. Sighing is a disturbance of respiration frequently associated with disturbed emotions."

In 1960, G. G. Jackson reported his findings in groups organized very much in the fashion of the British study. Once again physical deprivation failed to increase infectivity. Psychologic factors, particularly the induction of stress situations or the "fortuitous" occurrence of endogenous emotional crises, produced a sharp increase in the ratio of positive takes. On the basis of pre-exposure projective studies it was determined that cold symptoms were much less likely to develop in individuals who did not believe they would experience the illness. And most dramatically, a small group of subjects developed cold-like symptoms from the instillation of a non-infectious salt solution.

The point seems fairly well established. Even the common cold is a psychosomatic disorder. Need more proof? May I refer you then to an ultimate authority—the hit musical "Guys and Dolls"—and specifically to the lament chanted by a distraught heroine who once again has had to settle for Saratoga rather than Niagara, with a fiancé who loves horses, dice and the lady—in that order. Remember her words, barely audible through the sneezes and sniffles?

> "From a lack of community property
> And a feeling she's getting too old
> A person—can develop a bad, bad cold"

SANFORD M. LEWIS, M.D.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Medical Almanac 1961-62. Compiled by Peter S. Nagan, M.S. Philadelphia, 1961. Saunders, Pp. 528, Paper Binding. ($5.00).

It's about time somebody compiled this book. Packed into 528 pages is an enormous mass of usable non-clinical data. The text covers medical and specialty societies with their meeting dates and officers; income tax regulations; licensing rules; scheduled medical meetings; prevalence figures on all sorts of diseases; medical periodicals; (our JOURNAL is listed, of course); Congressmen; proposed Relative Value fee schedule; narcotic regulations; data on medical manpower; medical schools (all over the world); National Institute of Health grants; USPHS research possibilities; parcel post regulations; vital statistics, and so on. Unhappily the book is poorly bound and I am afraid the pages will readily become loose. But already this compendium has won a place on our book-shelf. It offers a remarkably compact source for the information we ought to have at our finger tips but often can't locate in a hurry. It is hoped that Saunders will issue one every year and perhaps make available a hard cover edition.

HENRY A. DAVIDSON, M.D.

The Mentally Disabled and the Law. F. T. Lindman and D. M. McIntyre. Chicago 1961, University of Chicago Press. Pp. 445. ($7.50)

Every physician who works with the mentally or emotionally ill has frequent points of contact with the law. This is a fluid field and it is hard to keep up with the changes. Furthermore, the United States is unique in having more than 50 different jurisdictions; so what is the law in one state may be anathema in another. This volume is a road-map through that jungle. The authors consider guardianship, criminal responsibility, sexual psychopathy, commitment procedures, voluntary hospitalization, eugenic sterilization, and the medicolegal aspects of marriage, divorce and annulment. A unique feature of the book is a state-by-state tabulation which shows what the rule is in each jurisdiction from Alaska to Wyoming. Each chapter closes with specific recommendations for bringing the law into line with modern psychiatry. This new book makes all other texts obsolete, since it is right up-to-the-minute. It should be the standard reference work in psychiatric jurisprudence for a long time to come.

ABRAHAM LEFF, M.D.

At Your Best for Birth and Afterwards. By Eileen Montgomery. Baltimore, 1960. Williams and Wilkins. Paper. Pp. 59. ($1.75)

Mrs. Montgomery, an obstetrical nurse, has written this as a manual of exercises for expectant mothers. Physicians who want their pregnant and post-partem patients to practice these maneuvers will find this slim pamphlet a handy aide. The booklet contains 20 outline drawings which illustrate the various postures and exercises.

VICTOR HUBERMAN, M.D.

Respiration in Health and Disease. By R. M. Cherniack, M.D. and L. Cherniack, M.D. Philadelphia, 1961, Saunders. Pp. 403, illus. ($10.50)

Most of the material in this book is available elsewhere, but it is here assembled into a unified and comprehensive structure. This volume starts with "Basic Considerations." These chapters discuss the mechanics of breathing, its regulation, the transport of carbon dioxide and oxygen, the regulation of the acid-base balance and the distribution of gases and of blood in the lungs.

The last section, "The Assessment of the Respiratory Disease," describes the symptoms and signs of respiratory disease. The authors present some material which is new to me, and they bring a fresh viewpoint to the old subject of physical diagnosis of the thorax. Of particular interest is their presentation of the timing of rales in the respiratory cycle.

The "Patterns of Respiratory Disease" is the title of a section on bronchial disease, pulmonary parenchymal disease, pulmonary vascular disease,

pleural disease, mediastinal disease, diaphragmatic disease, diseases of the chest wall and thoracic cage, and cardiopulmonary insufficiency.

The last section, "The Assement of the Respiratory Disease," includes material on clinical assessment, radiologic assessment, clinical-pathologic assessment and functional assessment.

Treatment is not discussed. Diseases are not described under individual headings but are mentioned only in tangential fashion. For example, "aminophyllin," "intermittent positive pressure," and "antibiotic" do not appear in the index. "Tuberculosis" is indexed only in connection with the tuberculin test and bacteriologic examination as diagnostic aids.

The authors state in the preface that "the clinician must have an appreciation of the mechanism by which the symptoms and abnormal signs are produced." They utilize this viewpoint successfully.

The type is distinct and the text is divided by frequent sub-headings, thus reducing the ordinary fatigue of reading. The illustrations are clear and make a considerable contribution. The illustrator is Nancy Joy, Assistant Professor of Medical Illustration at the University of Manitoba School of Medicine.

This book is recommended to all who are interested in the basic facts of normal and pathologic lung function.

DAVID BIBER, M.D.

Somatic Stability in the Newly Born. A Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and Maeve O'Connor. Boston, 1961, Little, Brown & Co., Pp. 393, illus. ($10.00)

This is an excellent and typically British review of some of the world's best work on newborns. The thoroughness, conciseness, and international flavor make interesting reading even to the less scientific of us.

The presence of agriculturists and veterinarians is a marvelous addition. When newborn piglets or lambs are used in studies these men not only contribute to our knowledge but learn for themselves.

Individual approaches are presented as separate chapters followed by a discussion of the whole group. Metabolism of carbohydrates, kidney function, effect of nutrition, asphyxia, endocrines, enzymes, oxygen consumption, temperature, nervous systems, and so on, are presented thoroughly and with illustrations. There is an interesting chapter on the relevance of anencephaly to problems of somatic stability. One author states that glycogen is the primary source of energy in the newborn—both human and animal.

The use of the word "stability" in the title gives everyone the opportunity to point out how relatively unstable newborns seem to be. Dr. McCance's introductory comments include the question "Why are the steady states of infants so labile?"

C. A. Smith shows the direction of the thinking of the conference by these questions: (1) Is there a special value in an instability of adjustment? (2) Is the adjustment achieved by the newborn infant actually so unstable as we may have thought?

He expresses the opinion that, as a result of this symposium, they have found more and narrower adjustments on the part of the infant than they had thought were there.

This book is recommended for those seeking a scientific account of studies on the newborn.

PHOEBE HUDSON, M.D.

Pharmacology: The Nature, Action and Use of Drugs. By Harry Beckman, M.D. Philadelphia, 1961. Saunders. Ed. 2. Pp. 805. ($15.50)

Medicine is, and should be, the primary concern of medicine. Three years ago Dr. Beckman offered *Drugs*, a text that swiftly won a unique place as a guide for students and practitioners. This new edition, like its predecessor, opens with an orientation to pharmacology, covering, in general, the source of drugs, their fate in the body and the factors that affect potency. The meat of the book is in the section on pharmacodynamics, covering all drugs that have therapeutic value. For each preparation there is an intelligently written discussion of the source and preparation of the drug, its dosage, side-effects, pharmacology, indications and so on. The text is thoroughly up-to-date and in spite of the whirlwind progress of pharmacology today, Beckman—1961 should be usable for many years to come.

ULYSSES M. FRANK, M.D.

Differentiation Between Normal and Abnormal in Electrocardiography. By Ernest Simonson, M.D. St. Louis, 1961, Mosby, Pp. 292. ($13.50)

This well-written book is filled with interesting data. The author has spent much time to accomplish this, and I know of no other cardiologist who has had the perseverence to accomplish it. The average physician who does cardiology will be lost reading this book. However, the well-trained cardiologist will find this book to be valuable. He will use it as a guide for his statistical foundation, and also as a roadmap to the prior work done by other authorities.

This text is a real asset in the field of cardiology.

WOLF LURIE, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

MAY, 1962 • VOL. XXXV, No. 5

DIFFUSE EXOCRINOPATHY (Cystic Fibrosis)

The disease commonly called cystic fibrosis, and sometimes mucoviscidosis, is due to an abnormality in the exocrine glands and the name exocrinopathy is suggested. The pulmonary lesion has the greatest clinical significance.

Gradually it has become apparent that "cystic fibrosis of the pancreas" is not primarily a pancreatic disease; neither is it a cystic or a fibrotic disease. The basic mechanism is a disturbance of the function of many of the exocrine glands of the body, structures that secrete their products externally onto an epithelial surface. The common denominator in this disease appears to be an abnormality in the composition of these exocrine secretions and clinical disease results when the secretions are sufficiently altered to cause dysfunction of the organ or organs involved.

The mucous glands of the tracheobronchial tree, the acinar tissue of the pancreas, the biliary canaliculi of the liver, the secretory tissue of the salivary glands, the sweat glands of the skin, and possibly other structures such as the gastrointestinal mucosa may be involved in this disease. After years of observation, D. H. Anderson, who introduced the term "cystic fibrosis of the pancreas," now defines cystic fibrosis as a "congenital familial disease characterized by dysfunction of many of the exocrine glands."

The clinical disturbances are variable and related to the type of the secretions and the function of the exocrine gland involved. Apparently the secretions of the pancreas, liver, and tracheobronchial mucosa are too viscous, while the abnormal secretions of other organs, such as the skin and salivary glands, apparently have normal viscosities.

CLINICAL ASPECTS

The disease is not uncommon. Its most significant clinical aspect is the pulmonary lesion, not pancreatic insufficiency. With growing appreciation of the pulmonary aspects of the disease, certain children with bronchitis, "chronic pneumonia," "whooping cough pneumonia" are now correctly diagnosed as having cystic fibrosis. The term mucoviscidosis, introduced in 1945, implied an increased viscosity in the secretions of the tracheobronchial tree, pancreas, and liver. The name had merit until P. A. di Sant'Agnese and associates discovered the electrolyte abnormalities of sweat in patients with this disease, but found no alterations in viscosity. While cystic fibrosis is still the accepted name, exocrinopathy would appear to be a more suitable one.

The exocrinopathy of the mucous secreting glands of the tracheobronchial mucosa produces the most serious effects of the disease. The tracheobronchial tree contains numerous mucous glands in its submucosa. Their secretions are most viscous and are cleared from the tracheobronchial tree only with difficulty.

JOHN A. PRIOR, M.D., *The Ohio State Medical Journal*, October, 1961.

Retention of the viscid material predisposes to infection and airway obstruction, either of which may predominate. During infections of the lower respiratory tract, the thick mucus results in prolongation of illness and favors development of serious complications.

Often cystic fibrosis may be suspected when a child fails to recover promptly from a "chest cold," "flu," or pertussis. Respiratory complaints—primarily cough, sputum production, and susceptibility to recurrent infections—may be minimal for years only to erupt at or after puberty into a progressive, relentlessly fatal respiratory disease.

Before pancreatic insufficiency is detectable clinically, 90 per cent or more of the pancreatic exocrine function has been lost. If this degree of loss is present at birth, meconium ileus may develop, causing an intestinal obstruction and accounting for approximately 10 per cent of the deaths due to cystic fibrosis. Patients spared meconium ileus will usually die primarily of pulmonary disease.

The most commonly described cystic fibrosis patient is a child who between the second and twelfth month of life develops steatorrhea and chronic recurrent respiratory infections.

SWEAT GLANDS

Parents of children with cystic fibrosis have observed that their children may taste salty when kissed. These children may also have a white, gritty material on their foreheads after exertion, and they may not "do well" in a hot spell.

In 1954 di Sant'Agnese and co-workers demonstrated that the electrolyte depletion was the result of the secretion of sweat containing excessively high concentrations of sodium and chloride. By metabolic balance studies, they demonstrated that the skin was the only route of the abnormal electrolyte loss. They devised a diagnostic procedure, known commonly as the "sweat test," in which the subject is exposed to thermal stimulus and his sweat is collected for analysis of the electrolyte concentration. In cystic fibrosis patients the sweat concentration of sodium and chloride is elevated from two to three times that of normal. There is no demonstrable correlation between the degree of electrolyte increase and the severity of the associated disease.

The marked variation in the severity of the disease is based upon inherited factors. It may be that the genetic factor can occur unexpressed clinically, thus some relatives of patients have abnormally high sodium and chloride sweat concentrations but no accompanying indications of disease.

DIAGNOSIS AND TREATMENT

The laboratory diagnosis of cystic fibrosis is based primarily upon the sweat test, which is positive in 99 per cent of known cystic fibrosis patients.

As in many other diseases, cystic fibrosis was first reported to be a rare but highly fatal disease. Although usually considered a disease of children, active disease has been found in individuals in the third and fourth decade.

Since the pulmonary disease accompanying cystic fibrosis is responsible for most of the deaths, particular attention to the lungs is indicated. The viscid secretions may be rendered thinner by the use of expectorants such as the iodides. Pancreatic streptokinase and streptodornase may be helpful in liquefying secretions.

For the control of infection, intensive courses of broad spectrum antibiotics each month for four or five days continuously are often helpful. In some instances, virtually year-round antibiotic therapy may be necessary to effect significant improvement. Cultures should be made of the sputum at regular intervals. Changes in the bacterial flora may dictate changes in antibacterial therapy.

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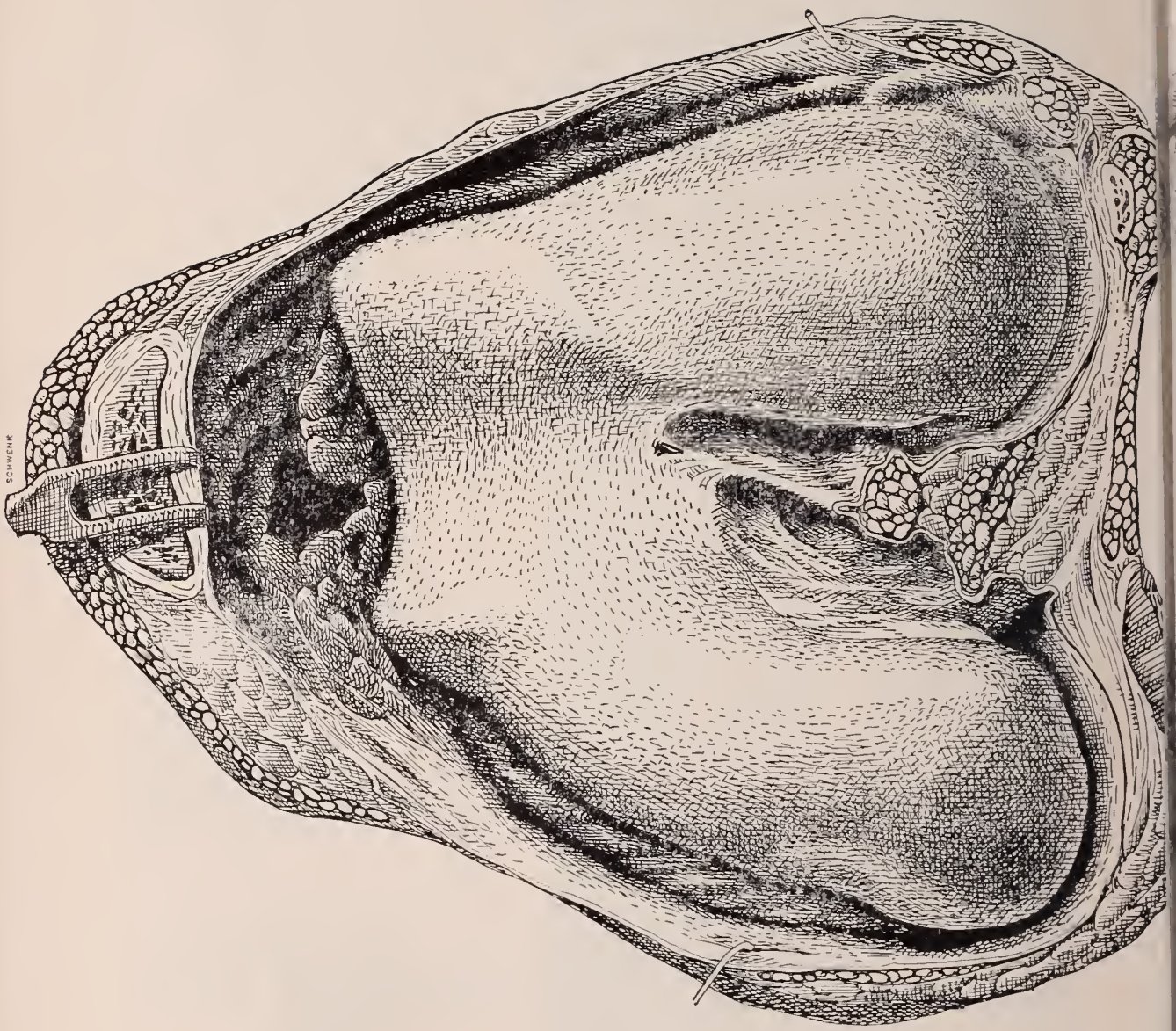
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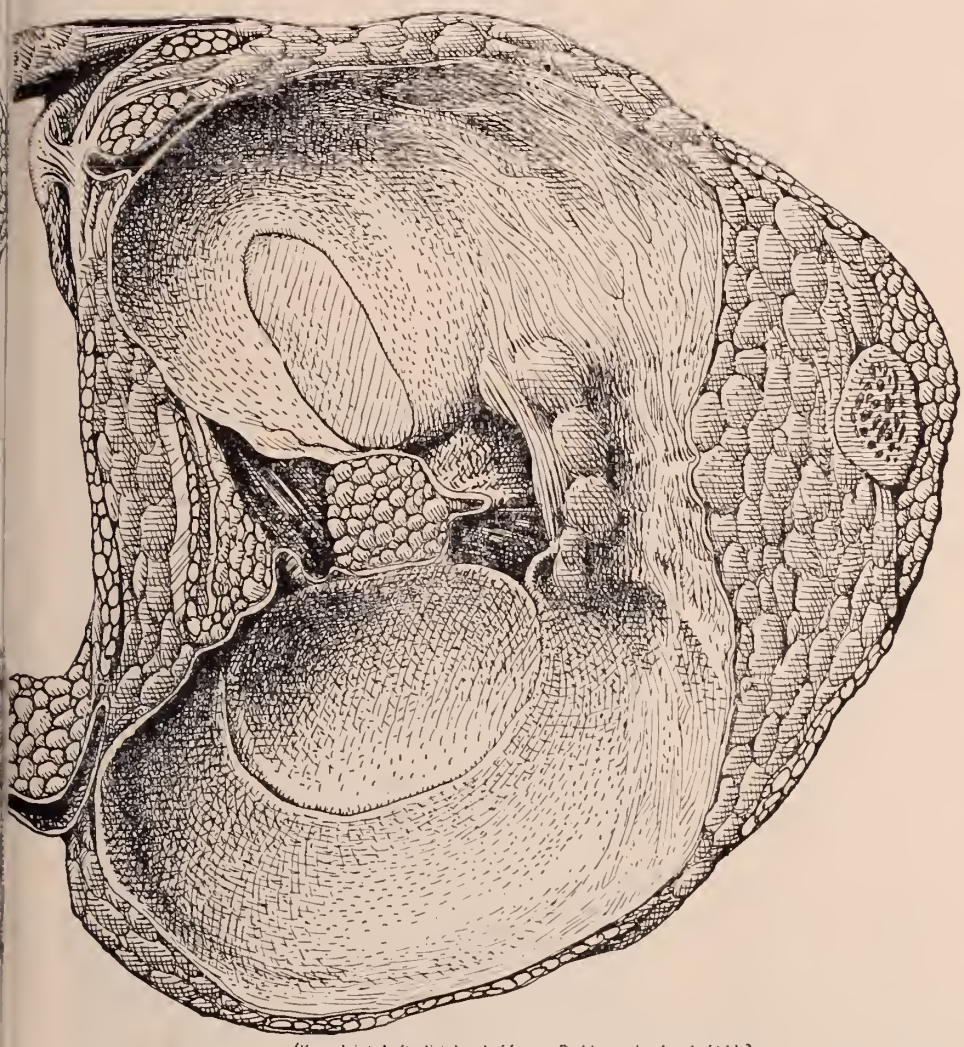
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Organon's new technical process now makes one of the newer, most highly potent and well tolerated corticosteroids available at greatly reduced cost to your patients with allergic, arthritic or other inflammatory conditions.

This new product is being marketed under the trade name of HEXADROL, brand of dexamethasone 'Organon'. HEXADROL is now being offered to your pharmacist at a price which should make it available to your patients at a cost well within the price range of older generically prescribed corticosteroids. It is supplied as 0.75 mg. white scored tablets, in bottles of 100.

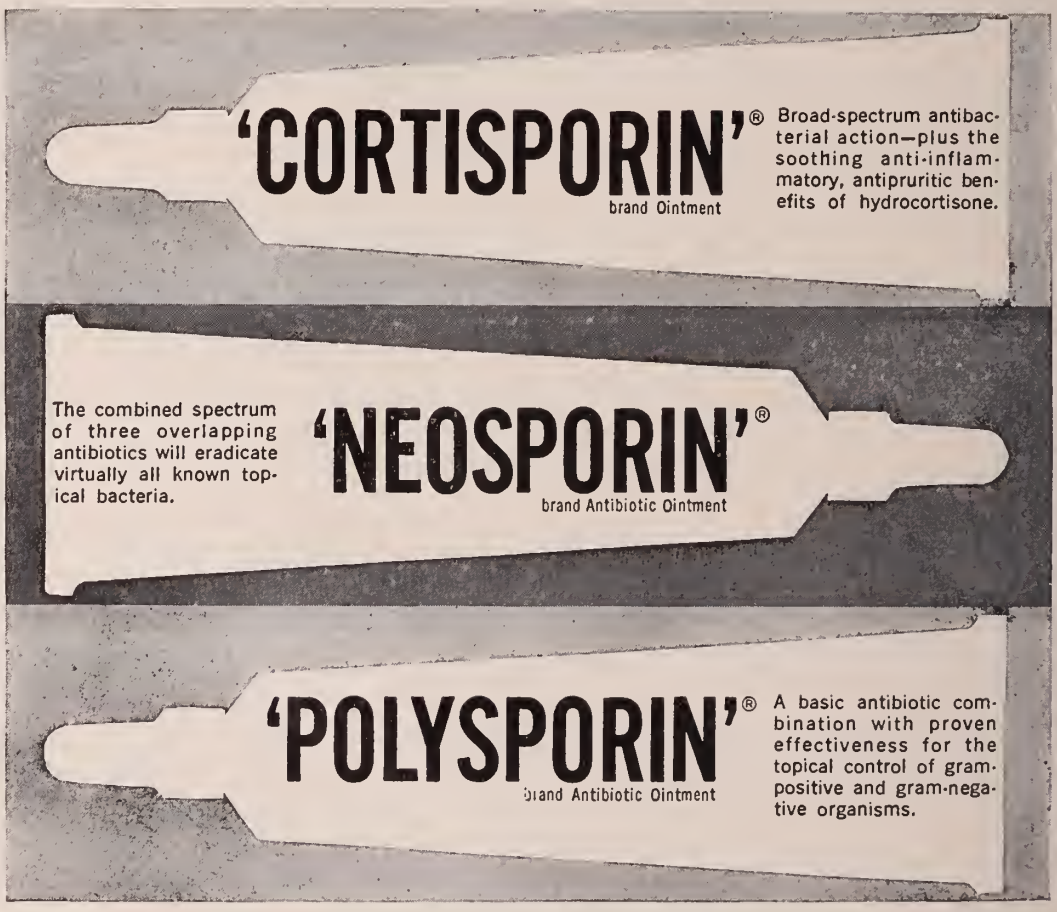
If you have been prescribing the older corticosteroids—such as prednisone, prednisolone, hydrocortisone or cortisone, and have hesitated to prescribe the newer corticosteroids because of economic consideration for your patients, you can now secure all of the clinical advantages of dexamethasone at approximately the same prescription expense. Mg. for mg., HEXADROL is approximately 6 times more potent than triamcinolone or methylprednisolone...8 times more potent than prednisone or prednisolone...28 times more potent than hydrocortisone...and 35 times more potent than cortisone.

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For complete information concerning HEXADROL—including indications, dosage, precautions and side effects—or if you would like a trial supply, ask your Organon Representative, or write to: Director, Professional Services, Organon Inc., West Orange, N. J.

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Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
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Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

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YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

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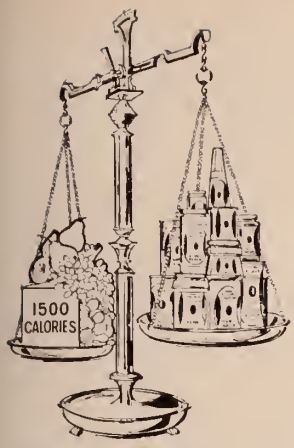
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Chopped Chicken Livers	1 oz.	31	100
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French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



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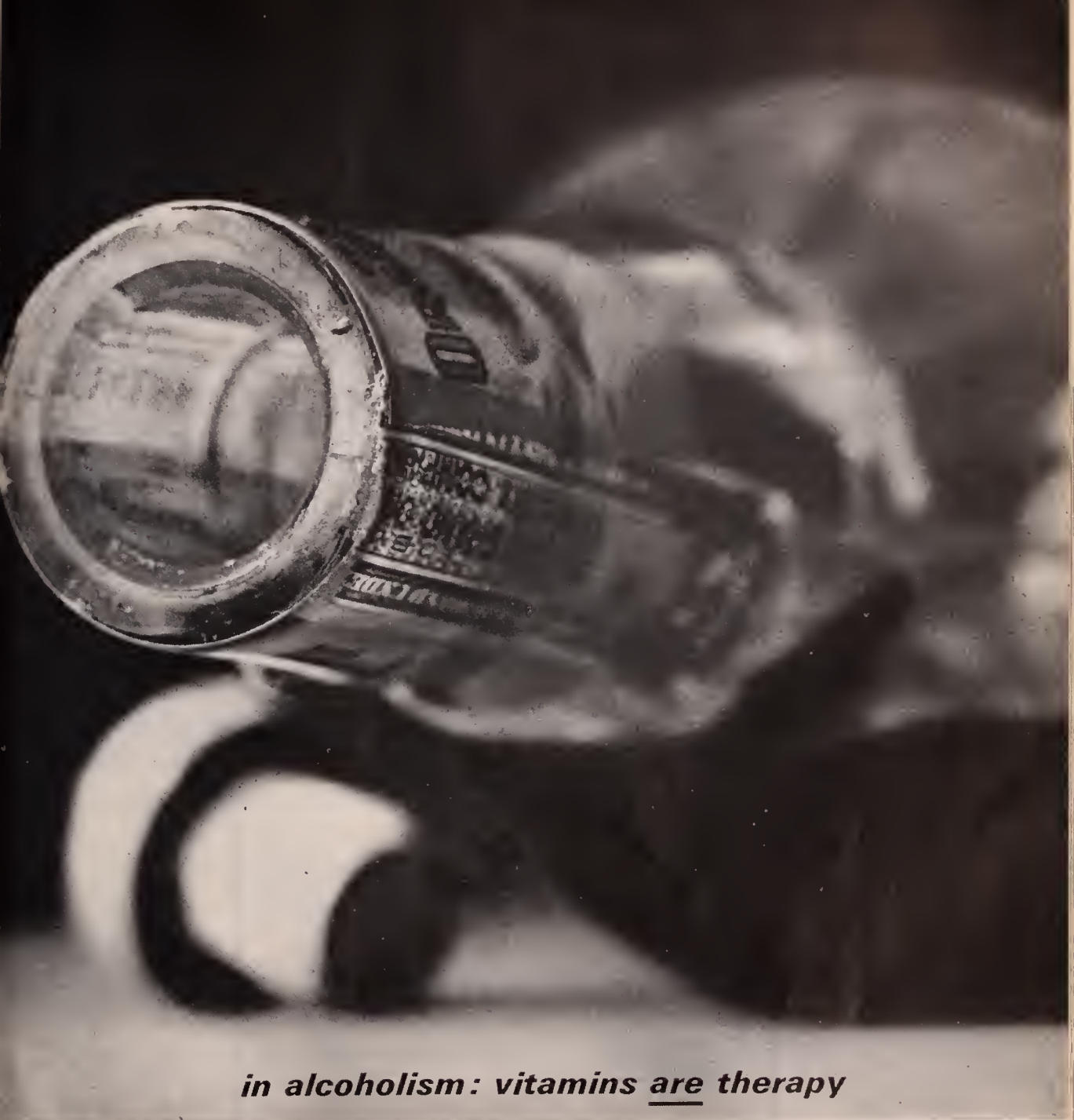
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Vitamin C (Ascorbic Acid)	300 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Calcium Pantothenate	20 mg

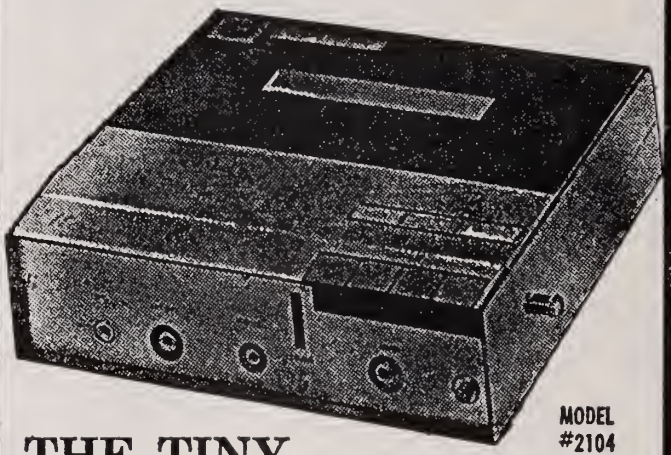
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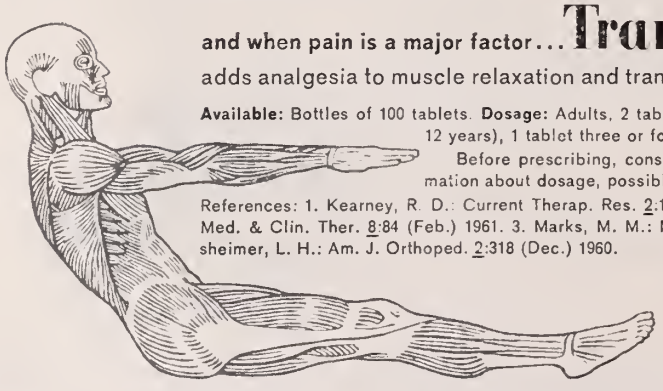
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Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. Kearney, R. D.: Current Therap. Res. 2:127 (April) 1960. 2. Cornbleet, T.: Antibiotic Med. & Clin. Ther. 8:84 (Feb.) 1961. 3. Marks, M. M.: Missouri Med. 58:1037 (Oct.) 1961. 4. Hergesheimer, L. H.: Am. J. Orthoped. 2:318 (Dec.) 1960.

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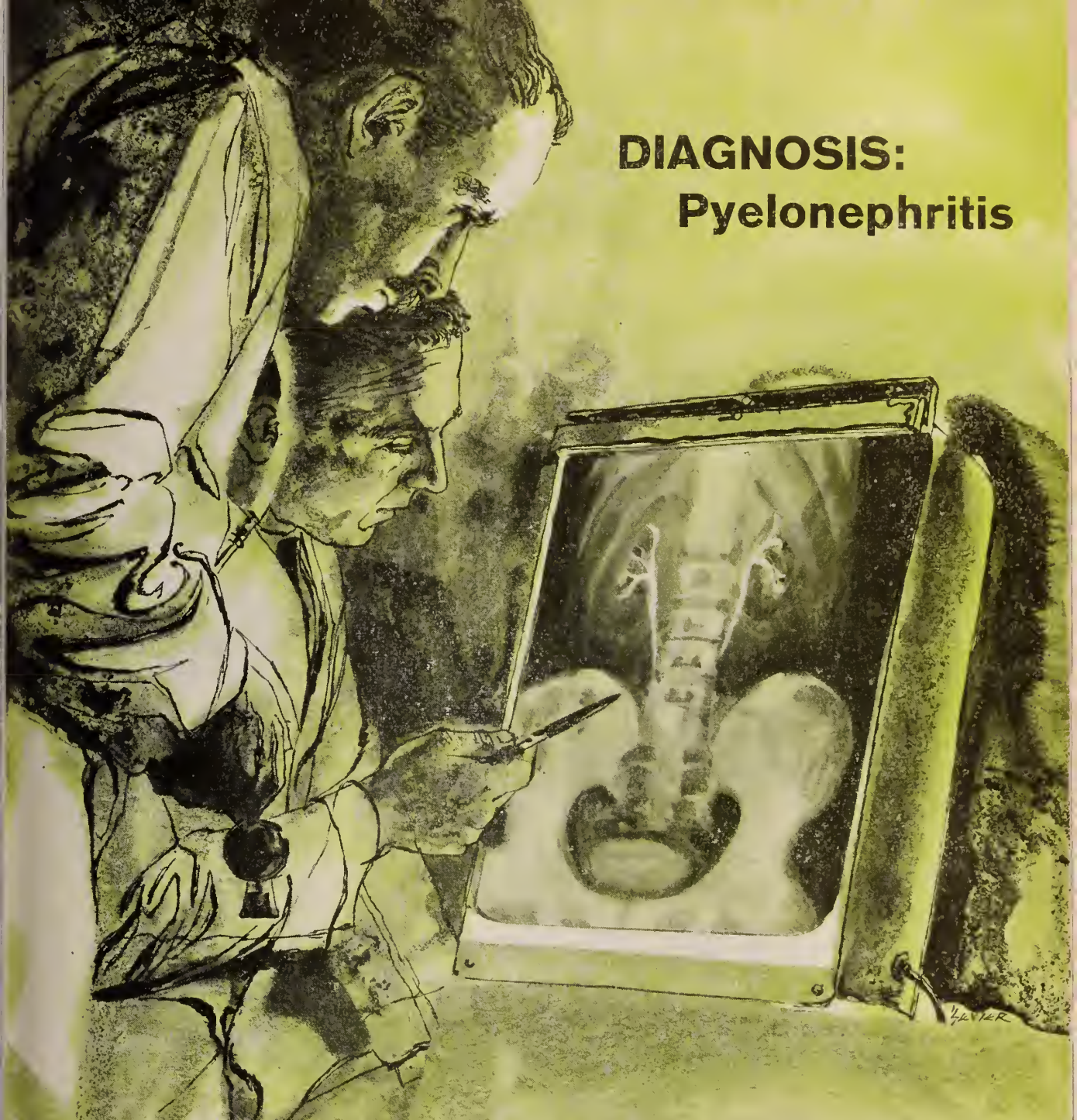
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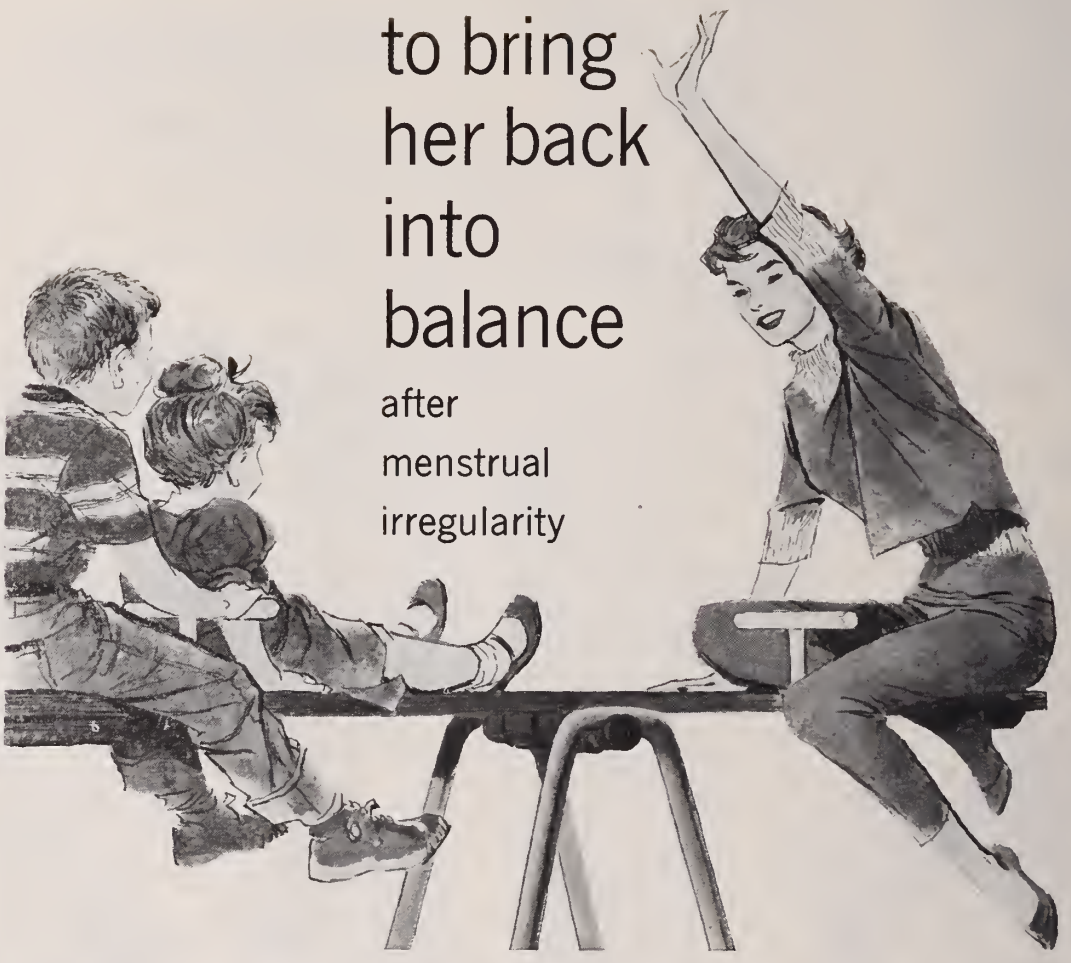
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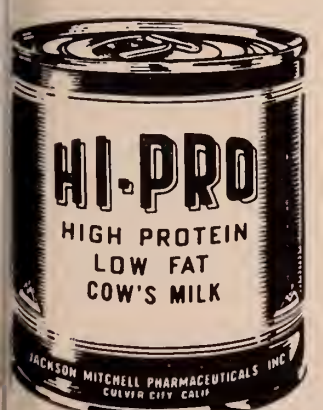
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Sunday, June 17, 1962
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EAU CLAIRE, WISCONSIN
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The Eau Claire Hotel

ATLANTA, GEORGIA
Wednesday, July 18, 1962
The Hotel Dinkler Plaza

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Sunday, September 9, 1962
The Granada Hotel

CLARKSBURG, WEST VIRGINIA
Sunday, September 9, 1962
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TYLER, TEXAS
Wednesday, September 12, 1962
Carlton Hotel

KANSAS CITY, KANSAS
Friday, September 14, 1962
Battenfeld Auditorium

WOODSTOCK, VERMONT
Wednesday, September 19, 1962
The Woodstock Inn

NIAGARA FALLS, ONTARIO
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Sheraton-Brock Hotel

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Holiday Inn

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Thursday, October 11, 1962
The Findlay Country Club

HONOLULU, HAWAII
Sunday, October 21, 1962
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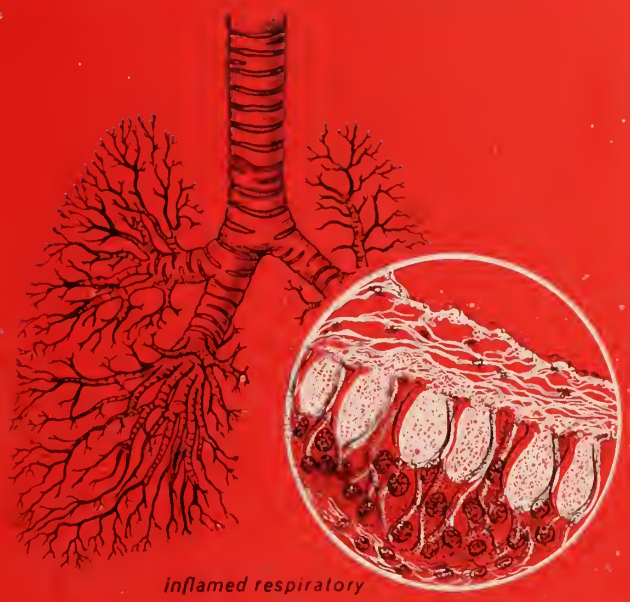
NEWARK, NEW JERSEY
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Robert Treat Hotel

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Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

INDIANAPOLIS, INDIANA
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1. Taub, S. J.: Clin. Med. 7:2575, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 3. Billow, B. W.; Cabodeville, A. M.; Stern, A.; Palm, A.; Robinson, M., and Paley, S.S.: Clinical Experiences with Oral Anti-inflammatory Enzyme for Intestinal Absorption. Southwestern Med. *41*:286, 1960.

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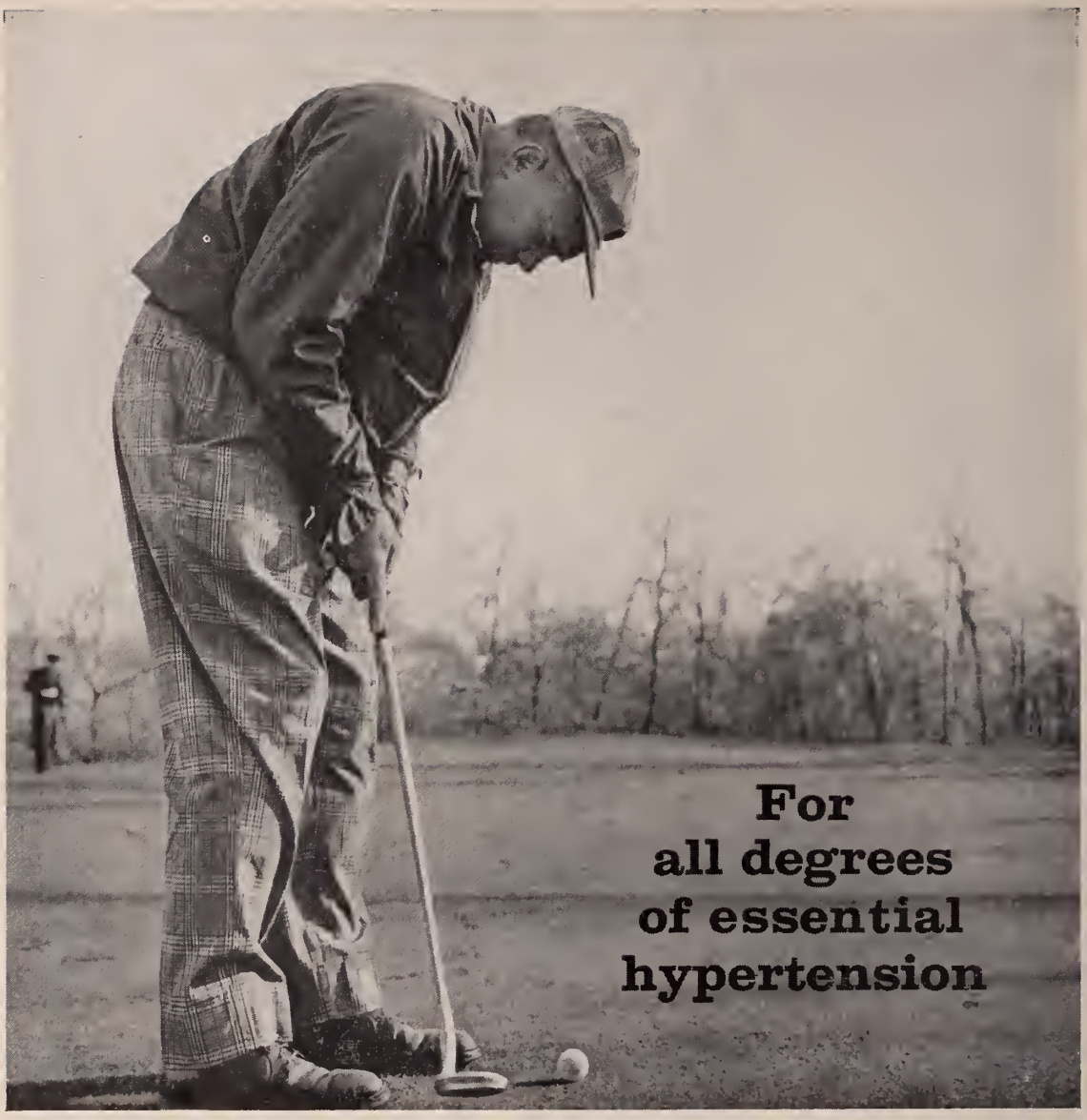


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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Here is Lou Wegryn



Leadership in medical organizations never goes to the poor physician. No doctor becomes a medical leader unless he enjoys the professional respect of his colleagues. Our new President wonderfully illustrates this, for Louis Stanley Wegryn is a skillful and prominent surgeon in Union County.

Dr. Wegryn was born in Elizabeth, New Jersey in 1903. He has practiced there for 35 years and has achieved a unique position not only in his profession but in Union County civic affairs. He holds a B.Sc. degree from the University of Illinois (1925) and an M.D. from the same University (1927). After interning in St. Louis, he did graduate work first in general surgery, then in gastrointestinal surgery.

Dr. Wegryn's leadership talents are illustrated by a surprising number of presidencies. On the national level, he has been president of the Association of American Physicians and Surgeons. He is director of surgery at Alexian Brothers Hospital in his native city. He had a busy tour of duty as president of the Union

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County Medical Society. He has served as president of the International Academy of Proctology. He has been Police Commissioner in the city of Elizabeth.

Our new President is active in many medical organizations. He is on the editorial board of the *American Journal of Proctology*. He is affiliated with the American College of Gastroenterology. He is active in New Jersey's well-known Society of Surgeons.

Dr. Wegryn's civic activities include pioneer service as a Housing Commissioner in Elizabeth, and yeoman service on civic welfare committees of many fraternal organizations and service clubs.

On the personal side, it is to be noted that Dr. Wegryn is married to the former Edna Mae Pennington, who comes from Missouri. One of their sons is a medical student at Cornell, and one is a physician in Elizabeth. Their daughter, Mrs. Alfonso Marroquin lives in Madrid, Spain. With the busy life our new President leads (and this year it's going to be busier) he doesn't have much time for hobbies —but when he does, he enjoys skiing and goes to New Hampshire for a while every winter for that purpose.

The Medical Society is not the only organization that has had occasion to elevate Dr. Wegryn to leadership. In addition to the imposing roster listed above, one more chief-ship must be mentioned. In 1952 he joined former President Eisenhower as an Honorary Chief of the Ottawa Tribe of American Indians. His Indian title is Great Elk. Dr. Wegryn thus offers us a dazzling variety of talents and a rich background of leadership.

He takes office at a time when organized medicine will need strength in its leadership. This has always been the tradition of The Medical Society of New Jersey: strong leaders who plough a straight furrow. Dr. Wegryn is a worthy addition to those ranks.

Lancelot Ely, M.D. — 1875-1962

When Lancelot Ely died last month, the *Lakeland News* called him "The Last of the Torch Boys." This referred to his activities in the o'd fashioned, horse-drawn volunteer fire brigade—in this case, Protection Hook and Ladder Company No. 1. It had, however, a symbolic meaning, too. For in those days, doctors were in the thick of things in civic activities. Lancelot Ely was not only a "torch boy." He was a proud military man—first, on active duty in World War I; then in the active reserve; then—as a colonel—in the inactive reserve. He was a pioneer archeologist and one of the founders of the New Jersey Archeologic Society. He contributed a substantial collection of American Indian relics to the New York Museum of the American Indian. He was a member of the Board of the New Jersey State Museum. And he was one of those selfless, dedicated family doctors who gave us the spiritual heritage on which we are now living.

Born in England in 1875, his family took him to the United States when he was seven years old. The Ely's were tailors—at a time when a tailor was an artist not a tradesman. He was given the unusual and romantically optimistic name of Lancelot. His brother Newton established a custom tailoring shop in Dover and there Lancelot was apprenticed. Then he set up his own shop in Boonton. But at night, he went to the New York Preparatory School. To many of our generation this would look like drudgery. Work all day in Boonton, New Jersey and then take the train, the ferry and the horse-cars to school in New York. But he did it, and in 1900 he entered the College of Physicians and Surgeons in Baltimore. Getting his M.D. in 1904 he settled in Flanders, New Jersey. Two years later he moved to Somerville.

At Somerset Hospital he served the staff in all ranks from clinical assistant to chief. He served The Medical Society of New Jersey on many committees, chairmanships, Trustee and Officer positions, becoming President of The Medical Society of New Jersey in 1934.

To Chicago in June

Each year at this season it is customary to extend an invitation to all American physicians to attend the AMA's annual meeting. Each year it is also expected of the president to state that "this year's meeting will be the best yet." And this year it's true

Theme of the meeting is "Medicine in the Atomic Age." This broad theme covers almost everything in medicine. And this is just what the scientific program will do.

The twenty-one scientific sections are pooling their talents to bring the top men in the nation to deliver papers in areas such as nuclear medicine, mental health, tissue transplantation, inflammatory and ulcerative diseases of the small intestine, inhalation therapy, clinical cardiology, anticoagulant therapy, diagnostic problems and exfoliative cytologic methods.

And for those of you who swore "never again!" following 1956 when we last met in Chicago in 1956, allow us to point out that the 1962 meeting will be in the swank new McCormick Place, completely air conditioned. The steamy heat and cramped quarters of the old Navy Pier are just an unpleasant memory.

See you in June in Chicago!

The Twilight Zone

I remember my Grandmother saying that if she could have one wish it would be to "die with her wits on." Any poll of those over sixty-five will show that many are not so fortunate. For many in the twilight years of life the subtle anesthesia of senility dulls the mind, changes the personality, and perverts reality. Most difficult is that the transition from clarity to mental cloudiness is without awareness on the part of the affected individual. An unexplained change in attitude and reaction, a temporary loss of memory for recent events, and a sudden sharpness or suspicion which seems completely out of character are symptoms that can be refuted with no logical argument.

Walk through any hospital or nursing home and the evidence of these mental changes are all around us in the posture and complaints of the senile. The unmoving, the constantly moving, the querulous, the subdued, the seeking—all reflecting an unconscious turmoil, a need to be understood by the understanding. It is this understanding that is most difficult and demands the most of both laity and the medical profession. The great challenge is, in fact, to preserve mental health in the same manner that we have extended life expectancy through preventive health measures, elimination of disease and surgical "miracles." Not too long ago pneumonia was considered the friend of the old for it took them swiftly and mercifully; a normal and frequently welcome euthanasia. Can we doctors honestly say that what we now have to offer is better? In some few cases, perhaps yes; but in the vast majority, the swinging door of senility slowly envelops the older patient in an irreversible cycle of confusion.

In an era when we are reaching for the moon, it is obvious that much remains to be done in the field of mental changes in the aged. Whether the answer lies in education, drugs, or environment no one is sure. To people who live on and on, the specter of senility is real and in ever increasing numbers its victims fill our hospitals and nursing homes. While the answer is not now apparent, it is clear that much thought and effort must be given by American medicine toward a solution of the mental changes in the twilight zone of life.

—Robert B. Marin, M.D.

Louis S. Wegryn, M.D.
Elizabeth

The Role of the American Physician Today*

In this ringing challenge to our medical heritage, our new President sounds a call for action tinctured with idealism.

The honor that you confer upon me today I shall cherish as long as I live. The presidential duties which, by your gracious decision I now assume, I shall perform to the best of my abilities, so help me God!

The office of the presidency of The Medical Society of New Jersey is compounded of these two elements of honor and duty.

The presidency honors the incumbent with the tribute of the esteem and the confidence of his colleagues, who have selected him for the highest office within their power to bestow. It honors him, also, with the status and dignity of serving as official leader and spokesman of the Society for the term of his office. And finally it honors him by admitting him to equality with the long line of illustrious presidents of The Medical Society of New Jersey who have preceded him.

The presidency imposes one all-embracing duty on the incumbent of the office by requiring that he do all in his power to assist the Society—in all its operations and in its every activity—to fulfill its committed purpose, by means of the cooperative efforts of all its members in the progressive exaltation of standards of professional and personal service, to serve, advance, and preserve the welfare of the people.

As the 170th president of The Medical Sosociety of New Jersey, with pride, humility, and profound gratefulness, I accept both the honors and the duties of this office. To the presidency, and to each of you, I pledge my conscientious best.

Since, as we have seen, the purpose of this Society can be realized only by the cooperative efforts of all our members, obviously I cannot do my full duty to assist in the realization and extension of that purpose of high service to the general good unless each member of the Society in turn is doing his proper part. If as a Society we are to be effective in the service of mankind and of the general good, it will never be sufficient merely for our officers and a limited number of our members to give their time and their efforts to our work. We must be united in purpose and in action. We must be totally dedicated and totally involved.

Every member-physician is equally obliged and called upon to do his or her part. Each of us must prove himself worthy of the honor, and responsive to the duties of his calling. Each of us must do his best to fulfill the role of the American physician today, for the satisfaction of his personal ideals, the enlargement of the worth of the profession of medicine, and the protection and preservation of the general good.

*Inaugural address, presented to the House of Delegates, 196th Annual Meeting, May 14, 1962.

THE role of the American physician today is perhaps the most exacting and challenging of all the professions. Certainly it is more complex and challenging than the role that physicians of any other generation of Americans have been called upon to face. Let us consider together what it involves . . .

The American physician of today, in common with other physicians of all times and places, is bound by the age-old, ennobling obligation to develop in himself, by constant study and training, the knowledge and skill necessary to use all available modalities of science and of art to restore the sick or stricken person to health, to help prevent the occurrence of illness or accident, and to extend the span of life for men and women in order that they may enjoy the fullness and the richness of their days.

The good that the physician seeks to bestow has come to be an object of universal, popular desire in America. As people succumb more and more to the pervasive and persuasive philosophy of materialism, physical health and creature comforts seem to have progressively displaced their hungers for spiritual health and soul's satisfactions. In our time, physical health and creature comforts seem to become, day by day, identified in the public mind as the highest good.

In other generations, men and women prized health and vigor for the advantage they would give them in enabling them to work longer and harder for the attainment of the goals which their human ambitions and their spiritual aspirations set for them.

Nowadays, people more and more want to be well and vigorous not to work longer or harder for the satisfactions of success, but to be able more fully to indulge their enjoyment of leisure and idleness. The lustre of work and the radiance of success are eclipsed, temporarily at least, by the synthetic brightness of irresponsible inaction. Free time has become highly prized but, unfortunately, not for the pursuit of competitive, self-sustaining activities, but rather as something freely expendable in the pleasures of self-distraction and self-amusement.

The consequence of this new social attitude manifests itself in a heightened interest on the the part of many in the condition of their health and—because of more free time to fret about it—a greater solicitude concerning it. The American physician today is called upon to assume responsibility for the satisfaction of the health needs not only of more people in consequence of the growth of our population, but of more demanding and exacting attitudes on the part of those patients who prize their health above all else, and themselves above all others.

The practicing physician in America today must realize all this. He must make himself available to all, so that he may serve all in proportion to their need. He must realize that the doctor-patient relationship is often akin to the parent-child relationship. His must be both the understanding and the compassion to realize that the fears of those who depend upon him, even if ultimately proved unfounded, are real for them, and therefore demanding of his time and solicitude.

Above all, the practicing physician in America today must not himself succumb to the prevalent popular emphasis upon, and desire for, free or leisure time. He must realize that, like parenthood, the profession of medicine is not so much a job as a way of life . . . a way of life ruled by, and based upon, fundamentals of maturity, dignity, love, and sacrifice.

Concurrently with the growth of the individual's interest in and concern for the state of his health, in America in the last generation medicine and surgery have made unprecedented and wonderful progress in the conquest of disease. Now, thanks to the genius of our scientists in all areas of medicine and surgery, life-saving developments have come about which spell better health and longer life for countless people who previously were doomed either to early death or to helpless invalidism.

It is, naturally, a source of tremendous satisfaction to physicians and surgeons to be able to bring the benefits of these new treatments, appliances, and technics to their patients. In ancient times, the physician was regarded as possessing almost divine powers because of even his limited ability to help and heal. But

today, in truth, he can almost matter-of-factly accomplish results that in other times could only be hoped for as miracles, to be worked by the power of God.

To some extent the American physician today suffers from an embarrassment of riches. More people desire the greater help and the wider boons that medicine and surgery can bestow. But progressively people, by and large, have less means themselves to pay for the services and benefits they seek.

This circumstance is not to be ascribed to attitudes of basic improvidence or irresponsibility on the part of the generality of our citizens. Rather it is the result of the relentlessly progressive appropriation of their individual incomes by governmental tax programs, at all levels, over the last third of a century, and the concomitant deterioration of the buying power of the dollars left to them.

In the absence of the possibility for the average citizen to build up any appreciable savings that would enable him to pay cash for services or commodities, it has become the rule in our country—where once it was the exception—to make all purchases on the deferred payment principle . . . to possess today what you will not own until the remote tomorrow.

As an alternative to this precarious method of purchase—appealing to the reckless, and necessary to the impecunious—the insurance mechanism, especially on the group basis, has been utilized by responsible people who have recognized in it a means, through spreading the risk, of preparing effectively to meet a necessary cost.

Appreciating the necessity and desirability of helping responsible and self-reliant individuals to meet the costs of extraordinary medical or surgical care by some practical means compatible with their reduced incomes, in 1942 The Medical Society of New Jersey effected the establishment of the Medical-Surgical Plan of New Jersey.

The Plan is made possible by the cooperation of those physicians and surgeons of New Jersey—well over 80 per cent of the total number of physicians in the State—who, as participating physicians, accept as full payment for eligible professional services rendered to eligible Plan subscribers, the payments assigned by the Plan. These professional fees are maintained below the average compensation for the same services rendered in private practice, and they represent the participating physician's contribution to the operation of the Plan and to the economic advantage of the subscribers thereto.

The people of New Jersey—employers, employees, and private citizens alike—have given incontrovertible evidence of their approval of, and satisfaction with, the Medical-Surgical Plan of New Jersey, by subscribing to it in the grand total of more than 2,253,000 as of the present time. Affording, as it does, all-inclusive coverage for eligible professional medical or surgical services rendered, the Medical-Surgical Plan supplies to its subscribers one of the greatest insurance and investment bargains in the nation today. Under group coverage, the cost for this protection to a family of father, mother, and all children under nineteen years of age amounts to $64.20 a year, or $5.35 a month or less than 17.6 cents a day. If that family consists of father, mother, and six children, the per capita cost for this full insurance protection is 2 and two-tenths cents a day! If the employer pays the premium in whole or in part—as most employers do—the cost to the family subscribing is proportionally diminished.

Perhaps this is why during the year 1961 the Medical-Surgical Plan of New Jersey ranked first among Blue Shield Plans in the United States in the acquisition of new subscribers.

The Medical-Surgical Plan of New Jersey—the New Jersey physicians' plan for insurance against significant medical and surgical expenses—is, as I have intimated above, also known as the "New Jersey Blue Shield Plan." All too frequently it is confused with the New Jersey Blue Cross Plan—which is a companion, though separate, insurance plan to protect subscribers against the costs of hospital services.

Of necessity, in consequence of the constant upward spiral of wage levels (salaries

account for 65 per cent of the operating costs of New Jersey hospitals), and as a result of the constant development of new instruments and machines for diagnosis and treatment, and of increasing awareness and utilization among subscribers of the expanding benefits and services available to them for the maintenance of good health, the Blue Cross Plan from time to time has had to apply for subscription rate increases.

Criticism that is levelled against the Blue Cross Plan is frequently mistakenly directed against the New Jersey Blue Shield Plan—our Medical-Surgical Plan. It is our obligation as practicing physicians and members of our communities to correct all tendencies to confuse the New Jersey Blue Cross with the New Jersey Blue Shield.

We should make it clear that we as physicians and surgeons and members of The Medical Society of New Jersey have no influence or voice in controlling the New Jersey Blue Cross Plan. We should—with pride—claim the Medical-Surgical Plan as our creation and responsibility, and bend every effort to see that it is recognized for the sound, economical, and outstandingly satisfactory insurance program that it is.

The matter and method of payment for the costs of health services of all kinds have involved the American physicians of today in considerations centering about not only the health and survival of individual American citizens, but the health and survival of our nation itself.

As we have already seen, the average American citizen today has about all that financially he can do to meet the day-by-day expenses of living, for himself and his dependents, out of such earnings as are left to him after taxes of all kinds.

It is true, as we have likewise indicated, that the average citizen's idea of what conveniences and comforts are basic and indispensable to him is probably the most ample in the world.

In a nation whose industries and businesses are as productive and beneficial as ours, this is properly so. Adequate food, clothing, shelter, light, heat, refrigeration, transportation, and the instruments of home entertainment such as radio, television, and record players—all are part of the average American's expectation as to what, in creature comforts and conveniences, he should be able to afford. And he is affording them, though in some instances he commits in advance more income than his take-home pay supplies, but in that he is only following—though with less assurance that he will get away with it—the hazardous financial policies of government at both federal and state levels.

When, however, the average citizen is faced with paying for services that he needs but in a sense does not want (for who wants to be sick, or to have an operation, or to be immobilized under treatment in a hospital?) then he discovers he doesn't have enough money to enjoy his life as an American . . . and sickness, too.

I SHALL not in this address discuss the proposal to have the government supply health services "free"—as a sort of pilot study, as it were—for all people over 65 years of age who are receiving Social Security benefits, except to point out that the costs would have to be met by taking more out of the earnings of all those workers paying into Social Security.

The upshot would be that their take-home pay would be further reduced and the possibility of their being able to meet other family costs—as for instance private education for their children—would be destroyed.

The American physician of today as a responsible and thoughful citizen knows that the health and survival of our country are bound up with the freedom, the industry, the productiveness, the independence, the self-reliance, the aspirations and the physical and moral vigors of the American people. As a responsible and thoughtful citizen, he knows that the government has no money to pay for anything that it does not extract from the pockets of the people. He knows that to contend otherwise is dishonest, and to encourage our people to be-

lieve otherwise is to jeopardize their freedom and welfare and therefore to jeopardize the freedom and welfare of our country.

The American physician of today therefore must carry on in the high traditions of his humanitarian profession by learning and doing all things necessary for the good of his patients. He must, in a professional sense, serve and care for his patients. But over and above all this, as a citizen—for his patients' sake, for his own and his children's sake—for his country's sake, he must encourage citizens not to surrender to government their personal independence or responsibility, but to insist instead in protecting themselves and the government from irreversible commitments that would inevitably be disastrous for them, for our country, and for the world.

As American physicians of today, this is your task and mine. Let us realize it and live only to fulfill it . . . And may God help us to succeed!

257 Elizabeth Avenue

Giant Leap — Backwards

The health of Red China's 600 million people is in the hands of "perhaps the most undertrained, medievally oriented, and politically infected medical profession in the world," according to Arturo F. Gonzalez, Jr. Writing in the 1962 *Today's Health*, Gonzalez said in 1958 the Red Chinese took "a giant step backward—a step they are still taking."

China's Western-trained physicians, the cream of the country's medical profession, in 1958 were summarily ordered by the head of Chinese public health, to revert to traditional Chinese methods in treating patients, he said. Thus, they were ordered back to the Dark Ages—and all were told to plan upon extensive "training" in traditional medicine, he said.

Traditional medicine, practiced for centuries in China, employs acupuncture, herbs (said to cure everying from appendicitis to fractures), breath control and shadow boxing, Gonzalez said. The traditional practitioners blame internal diseases on the "seven passions" and external diseases on "six excesses."

Until 1958, traditional practitioners worked side by side with Western-trained physicians, he said, and then the hammer fell. "The new-old Chinese theories of medicine read like an allegory out of Charlemagne heavily laden with Marxist dialectic," Gonzalez said. In a recent Red Chinese medical journal, he said, specialists were told to "establish revolutionary optimism and fight their diseases with strong will power."

"Politics intrude on every diagnosis," he continued. "The most common ailments, affecting perhaps 70 per cent of all patients, are dropsy and liver inflammation, caused by malnutrition and vitamin deficiency. Labeling the diseases for what they are marks a doctor as a 'rightist.' He can't believe there's malnutrition in the people's paradise?"

This is one of the reasons why Chinese medical men have been compelled to cut their ties with Western medicine so completely that even faced with a massive cholera epidemic they could not bring themselves to communicate the simple facts of the case to their Western colleagues beyond the Bamboo curtain, he said. This profession serves the world's most populous country. One can envision an eventual medical disaster which could make last year's 50,000 cholera deaths seem like a drop in the bucket.

Attempting to evaluate the impact on the world of China's great leap backward in medicine is almost impossible. If the Reds persist in ignoring epidemics and hiding their presence from the rest of the unsuspecting world it is not impossible to foresee some future disaster outside the Bamboo Curtain.

"But even if the free world escapes the perils of Chinese practice, what about the fate of the 600 million Chinese who today are being treated by the most undertrained, medievally oriented, and politically infected medical profession in the world? It is their plight which commands our sympathy and their fate which makes China's great leap backward in medicine the terrible human tragedy which it appears to be."

Harrold A. Murray, M.D
Sea Girt

The Voluntary Non-Profit Teaching Hospital

It is here suggested that, in the world of tomorrow, good voluntary hospitals will have full-time salaried chiefs of major clinical services, as part of a teaching program. These views are not those of our Medical Society, which has taken no stand on this matter. Dr. Murray assumes responsibility for the opinions here expressed.

For many years the medical profession and the governing bodies of our hospitals have recognized that a well organized and effective educational program inevitably results in the improvement of the quality of patient care [1] in a hospital. Intern and residency programs are essential for a total educational program to bring about this improvement in the quality of patient care.

The American Medical Association's 1961 Annual Report [2] on Graduate Education in the United States has brought to light many significant findings. The number of internships offered decreased in 1960. In New Jersey the proportion of internships filled was only 68 per cent. The ratio of foreign physicians in filled positions was 59 per cent. Some 382 hospitals were affiliated with medical schools; they constituted only 27 per cent of all hospitals approved for residency training, but they offered 54 per cent of the available positions. Although the affiliated hospitals were 4 per cent more successful than the non-affiliated in filling their available positions, it is clear, the report states, that university hospitals do not provide enough positions to accommodate all the physicians seeking residency training.

Voluntary teaching hospitals with a well organized and effective teaching program can provide such residency training. Difficulty in getting interns and offering residency programs has made many hospital administrators and their governing bodies realize the great need for expanding their programs in education. The voluntary teaching hospital can be a definite attraction for the graduate of a medical school seeking an internship. If adequate compensation is offered and good living quarters are provided (sometimes for their families too) the prospective intern or resident *will select the hospital which offers the best educational program.* Often it will be in the community in which they will ultimately practice.

ACCREDITED VOLUNTARY HOSPITALS

There are two kinds of accredited voluntary hospitals. The one most common in New Jersey is a hospital without a formal teaching program, sometimes with an intern

1. Journal of the American Medical Association, 174:774 (Oct. 8, 1960).
2. Journal of the American Medical Association, 177:620 (Sept. 23, 1961).

staff, or where house physicians render intern and resident services. The Joint Commission on Accreditation requires that the hospital's medical staff hold regular scientific conferences and suggests an attendance of 50 per cent of the staff. At these conferences a good educational program is generally conducted which enables the busy practitioner to keep up to date on the latest developments in patient care. Many patients and physicians are happy in these excellent community hospitals.

The second type of hospital, however, is the subject of this article. It is the voluntary non-profit teaching hospital. The primary aim of the governing bodies of these hospitals is to attract interns and residents and educate the attending medical staff so that improved patient care can be offered. Their desire also is to become affiliated with a medical school.

Several of these hospitals have appointed full or part-time directors of education. From an AMA questionnaire[2] it is learned that of the 850 hospitals replying, 375 had full-time directors and 495 had part-time directors of medical education. This is an accepted procedure in a good teaching hospital. Many of our New Jersey hospitals have full or part-time directors of education. Some have engaged instructors from the medical schools as chiefs of the various departments of the hospitals.

DEPARTMENTAL CHIEFS

IN THE organization of this division of the educational program, the chief of the medical staff is responsible for the functioning of the clinical organization. A president, vice-president, secretary and treasurer will be elected by the active medical staff as is the practice in any well organized hospital. These officers will *not* be a part of the general teaching program. In each major department (such as surgery, medicine, obstetrics, gynecology and pediatrics) there will be a full or part-time chief from one of the medical schools who will have general supervision over the clinical work falling within his department, whether that work be "service" or private. He will be responsible for the educational program and the administration of the department, including planning for hospital facilities, routine procedures and other matters concerning patient care. Under this plan all patients, private or "service," will be admitted as part of the educational program. A referring physician may exclude his patient from participation if he so indicates on the medical chart.

Departmental chiefs should be appointed on a yearly basis and should *not* be permitted to engage in private practice in the community. An Advisory Committee of three or more attending physicians from the department should be elected by the members of the department to work in close harmony with the chiefs. No major decision should be made without the approval of this Committee.

COMMENT

MANY attending staff physicians are excellent teachers but their very busy schedules prevent them from participating in the formal teaching program. The chiefs will be a great benefit to them because, being affiliated with medical schools, they will bring to the hospital the very latest information on newer medical and surgical procedures.

Although neither the American nor the New Jersey Hospital Association has taken a definite stand on this procedure, it is thought by many that, sooner or later, this will be an accepted practice in a good hospital teaching program.

Staff physicians who have not been well informed of the principle involved in this part of the education program are sometimes deeply concerned. They fear that their privileges and positions in the hospital will be jeopardized. The program is new to them and to the governing bodies. Much education is needed to allay their fears. Governing bodies should be tolerant of this apprehension on the part of the medical staff and slowly bring about this newer concept in medical education.

If carefully organized and supervised, the procedure of appointing at first either full or part-time chiefs to one or two of the major departments of the hospital will be a good one. There will be a need for these chiefs in an approved residency program.

SUMMARY

1. The primary objective of the voluntary non-profit teaching hospital should be the institution of an adequate educational program which will attract interns and residents and will be a source of instruction for the medical staff.

2. The duty of the governing bodies of these hospitals is to select a competent director of education with as many departmental chiefs as are needed to implement the program. The educational department should work harmoniously with the medical staff.

3. The medical staff should realize that sooner or later this procedure will be the accepted one in a good teaching hospital. Acceptance of this will take time and patient understanding on the part of the medical staff and the governing bodies of the voluntary non-profit teaching hospitals.

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Transvestism

A desire to wear clothes of the opposite sex is known as *transvestism*. Writing in the Journal of Pediatrics (56:294), Harry Bakwin points out that transvestism is more common in children than in adults, but is generally disregarded by pediatricians. It should be distinguished from sexual inversion, in which there is adoption of the psychologic identity of the opposite sex.

Only a small percentage of adult transvestites are homosexuals. Transvestism is commoner in boys than in girls and is usually first noted in the fourth year. In the 7 boys reported there was no evidence that the parents would have preferred a girl.

The etiology is some conditioning experiences in the first three years. Sadomasochism or fetishism may be concerned. There may have been difficulties in sex assignment owing to some degree of hermaphroditism. Hormonal studies have revealed no abnormalities. In males, the chromosomal pattern is normal. The majority of these children grow up into normal adults.

Treatment should begin as early as possible. First step is a detailed review of the home situation, with special attention to the parents' attitude to one another and to the child. The dominating mother needs curbing, and the too-passive father should be encouraged to take a more active part in the child's life; the patient should be encouraged in the behavior that is characteristic of his sex, and discouraged from behaving like the opposite sex.

Coercion, teasing and shaming may be harmful by rousing the child's negativism. Confusion about sex should be clarified and explanations given in terms which the child can understand. A transvestite child should be guarded against undesirable emotional attachments. If parental resistance is encountered or the child's behavior seems deeply intrenched and does not respond to general suggestions, psychiatric help should be sought.

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Traumatic Hemobilia*

Only 24 cases of traumatic hemobilia have been reported in all the literature. To this meager collection, the Martland Department of Surgery adds two new cases.

The term "traumatic hemobilia" was suggested by Sandblom[38] in 1948 to describe hemorrhage into the biliary tree secondary to traumatic injury to the liver. The first reported case of laceration of the liver was cited by Owen[31] in 1848 from an autopsy. According to Sparkman,[40] Burns was the first to attempt surgical treatment of a liver wound in 1870.

Hemorrhage into the biliary tree has been reported from many sources and is classified as follows:

I. Trauma
   1. Liver (see text).
   2. Biliary tract surgery.[9,15,49]
   3. Intubation of common bile duct causing fistulas into the right hepatic artery or superior pancreatico-duodenal artery.[33,5,34,15]

II. Rupture hepatic or portal aneurysms—intrahepatic;[25,86] or extrahepatic.[30,14,6,1]

III. Stones—biliary tract.[35]

IV. Tumor—liver;[10,36,27,23,48] biliary tract.[47,11,24]

V. Inflammation—liver;[13] gall bladder.[43]

Traumatic injury to the liver is relatively frequent; indeed, except for the brain, it is the organ most commonly affected by blunt violence.[32] Central and subcapsular lacerations occur from internal stress and contrecoup injury. In penetrating abdominal wounds, the liver is involved in 34 per cent of cases.[50] Despite the relative frequency of traumatic injury to the liver, hemobilia is infrequent. To develop hemobilia, the injury must produce a communication between a blood vessel and the biliary tree in a closed space.

Twenty-four cases of traumatic hemobilia have been reported in the literature. (See citations numbered 2, 23, 3, 4, 7, 8, 12, 17, 18, 19, 20, 21, 22, 28, 29, 31, 37, 39, 40, 42, 44, 45, 46 and 51 in the authors' reprints.) Of these 24 cases, only three were females.

Sandblom[38] described a triad of symptoms characterizing traumatic hemobilia: (1) gastro-intestinal bleeding; (2) pain simulating biliary colic; and (3) jaundice. Analysis of the 24 reported cases reveals that the initial episode of hemobilia occurred from 16 hours to four months after trauma. The average was 30 days. The hemobilia was manifested by hematemesis and/or melena, anemia, and occasionally shock. Physical examination revealed right upper quadrant fullness and tenderness and, rarely, a palpable gallbladder. Icterus was a common feature.

Following trauma, the liver has remarkable recuperative powers so that the damage is often not reflected in conventional liver function tests. However, Saliba[37] reported serum transaminase as a valuable diagnostic aid.

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Cholangiograms frequently showed nonvisualization. Clinically, hemobilia could be diagnosed in most cases only at laparotomy. In 46 per cent, surgery was done within the first day of injury. Eighty per cent of these required additional surgery for hemobilia at a later date. Hence, the autolytic and erosive effects of necrotic and devitalized liver appear to be a variable process.

Mortality in the reported cases was 38 per cent. However, there were only four deaths in 15 cases reported since 1941. Causes of death were hemorrhagic shock, peritonitis, sepsis, and kidney failure. Nonfatal complications included wound infections, liver necrosis, biliary fistula, and involvement of the lungs, pancreas and colon.

CASE ONE

A 32-year old male was admitted 4/7/61 because of right upper quadrant abdominal pain. Twelve hours prior to admission, he had tumbled down six steps and struck his right hypochondrium against a post. He had been under the influence of alcohol. He was a well developed, well nourished, 60 kg., alert but uncooperative. Vital signs were: pulse 110; respirations 20; blood pressure 100/60. No postural hypotension or sweating was noted. He complained of pain in his right shoulder when in a supine position but not in a sitting position. Breath sounds were diminished in the right lower lung field. A sinus tachycardia with no murmur or enlargement of the heart was present. The abdomen was slightly distended. A linear contusion paralleled the right costal margin anterolaterally. The right upper quadrant was extremely tender with moderate muscle guarding. Peristalsis was hypoactive.

On admission, hemoglobin was 11.4 Grams; hematocrit 32 per cent; W.B.C. 12,500—stabs. 10 per cent, segmented polymorphonuclear leucocytes 62 per cent; lymphocytes 20 per cent; monocytes 8 per cent; serum amylase 254 somogyi units; fasting blood surgar 110 mg. per cent; blood urea nitrogen 50.

Lung fields were roentgenologically clear and heart was of normal size and configuration. No ribs were fractured.

The patient was difficult to manage during his entire hospital stay. The gastric Levin tube drained frank blood. Four hours after admission, a count revealed a drop in hemoglobin to 8.8 Grams. Blood pressure remained stable. A catheterized urine specimen was scanty, yellow, cloudy, acid; albumin 3 plus; sugar negative; acetone negative; microscopic 14 leucocytes per high power field; 2 coarse granular and fine granular casts per field.

The patient was given a liter of whole blood and 500 milliliters glucose and water intravenously. Eighteen hours after his accident, at laparotomy, 3500 milliliters of bloody fluid were aspirated and 500 removed on pads from the abdominal cavity. Stellate lacerations of the right lobe of the liver, originating on the dome and extending posteriorly, medially and laterally, oozed dark bloody material. Each of these lacerations gaped 5 to 10 millimeters and extended up to 5 centimeters in length and depth. The biliary tree was normal. The lacerations were approximated with 2-0 silk sutures ligated over Oxycel® pads. Penrose drains, brought out through a stab wound in the right flank, were placed in the right subphrenic spaces. At the termination of the procedure, the patient had been given a total of 2500 milliliters in blood transfusions. His vital signs remained stable. The next day his hemoglobin was 12 Grams and hematocrit 35 per cent. Urinary output was 1450 milliliters.

Supportive treatment consisted of massive, versatile antibiotics parenterally, and Neomycin® orally. Electrolytic balance remained well regulated. Fluids were given to maintain a urinary output between 500 to 1500 milliliters daily. Additional care consisted of tetanus toxoid, multivitamins and minerals, A.C.T.H., hydrocortisone and magnesium sulphate.

He had a stormy postoperative course. Sepsis was marked for the first eight days with a daily spike in temperature over 101. Blood ammonia levels ranged from 0.15 to 0.17 milligrams (normal is 0.1 to 0.2 milligrams per cent). Serum transaminase (S.G.O.T.) on the third postoperative day was 200 units. Between the fifth to eighth day, the patient became confused, hallucinated and bellicose. On the eighth postoperative day, a dramatic change occurred: The patient lapsed into a comatose state for two days. Jaundice developed and persisted. Dark green to black, loose bowel movements were noted. Fever lysed. The hemoglobin dropped from 14 to 8.8 Grams.

For the ensuing two weeks, supportive care was intensified. An additional 4,000 milliliters in whole blood transfusions were required to maintain the patient's stability. On the seventeenth day, a low grade fever recurred for ten days. Melena ceased on the eighteenth postoperative day.

Three intravenous cholangiograms failed to reveal any dye excretion into the biliary radicals. A gastro-intestinal series was unsuccessful due to lack of cooperation of the patient. He was discharged on the forty-first postoperative day. Two months after the initial trauma, he was anemic and icteric but refused hospitalization.

CASE TWO

A 32-year old man was brought in 6/9/61 unconscious and in shock. He had sustained a gunshot wound in the upper abdomen. He was pale, cold, clammy and unresponsive. He had a weak, thready pulse at 130 and shallow respirations at 24. Blood pressure was 70/40. A small caliber bullet wound was present at the right costal margin. The abdomen was soft with slight tenderness in the immediate wound area. No organs or masses were palpable. Chest x-ray was negative. The bullet was embedded in the body of the first lumbar

veterbra. Hemoglobin was 61 per cent; hematocrit 30 per cent; W.B.C. 15,250—neutrophiles 66 per cent, lymphocytes 31 per cent, eosinophils 1 per cent; monocytes 2 per cent; fasting blood sugar 182 mg. per cent; blood urea nitrogen 15 mg. per cent. Urinalysis was negative.

A Levin tube was inserted into the stomach and frank blood drained out. Transfusions were started. At laparotomy, two liters of bloody fluid were aspirated from the free peritoneal cavity. A slowly bleeding laceration was found on the antero-superior aspect of the right lobe of the liver extending across the falciform ligament. A laceration marking the exit point of the bullet was found on postero-inferior surface of the liver in the vicinity of inferior vena cava. The puncture wounds were sealed with plugs of Gelfoam®. A Penrose drain was placed in Morrison's space and brought out through a stab wound. Two liters of whole blood were transfused into the patient. The patient completed an uneventful recovery and subsequently remained asymptomatic.

COMMENT

THE first case is interesting from many respects. A diagnosis of hemobilia was made pre-operatively on the basis of blunt trauma to the liver area by the aspiration of blood from the stomach through a Levin tube. What was most astonishing was the loss of four liters of bloody fluid into the peritoneal cavity without significant hypotension or syncope. On the eighth postoperative day, the patient developed signs of what can be interpreted as classical "delayed" hemobilia. This was manifested by coma, jaundice, melena, lysis of fever, and a rapid drop in hemoglobin. At no time during the ensuing eighteen days of persistent melena and anemia did the patient lapse into a hypotensive state. The patient refused surgery but responded fairly well to four liters of blood and supportive therapy. Anemia and icterus persisted clinically. The bile ducts were never visualized on three attempts at intravenous cholangiography.

In the second case, the diagnosis of hemobilia was made on the basis of gastric aspiration of blood through a Levin tube following a penetrating injury to the right upper quadrant. This patient responded well to surgical repair of the wounds and supportive therapy. He did not develop "delayed" hemobilia.

Treatment of liver injury *per se* consists of early operation preceded by adequate blood replacement. The operative procedure[41] will depend on the type and degree of liver involvement.

1. *Perforating*: In most instances, the perforation will seal itself and hemorrhage will spontaneously stop. A wound oozing blood or draining bile should be debrided and sutured with a plug of absorbable hemostatic material over the exit and entrance. The risk of creating a closed cavity is calculated.
2. *Sharp incised wounds*: This should be closed with heavy sutures.
3. *Fragmentation*: Extensive debridement may be necessary. Cavities should not be packed.[25] Spector[42] recommends an intrahepatic tube drain to prevent bile or blood accumulation in a cavity. In extreme cases, a main branch of the hepatic artery may have to be ligated and a partial or complete lobectomy performed.

The biliary tract may have to be decompressed if it is filled with blood or debris. Liberal drainage of the subphrenic spaces should be instituted anteriorly and through the flank posterolaterally in all injuries to the liver. Supportive care consists of massive antibiotics, fluid, electrolyte and colloid replacement, tetanus toxoid or antitoxin and multivitamins.

CONCLUSIONS

1. A classification of hemobilia is offered based on different causes as reported in the literature.
2. Traumatic hemobilia may occur (a) immediately following an injury to the liver, or (b) as a delayed response one day to four months later. The "delayed" hemobilia is characterized by: (1) right upper quadrant pain simulating biliary colic, (2) gastro-intestinal bleeding accompanying or following cessation of pain, (3) icterus, (4) lysis of fever.
3. Two cases of traumatic hemobilia are presented. These represent the twenty-fifth and twenty-sixth cases of this type reported in the literature.

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An extensive bibliography of 51 citations appears in the authors' reprints.

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Legg-Perthes' Disease*

Report of Thirty Cases

In this concise review, Dr. Root summarizes what the general practitioner should know about recognizing and managing Legg-Perthes' disease.

Legg-Perthes' disease is a self-limited disorder which occurs in children from the ages 3 to 11. Males are affected predominantly, and in 80 per cent of the cases the disease is unilateral. It is extremely rare in Negroes.

HISTORICAL REVIEW

Both Legg and Waldenström are given credit for first describing this disease. In 1909 Waldenström reported ten cases of a disease of the hip in children, which he felt was due to tuberculosis. In 1910, three authors independently described a hip disease in children which resembled that which had been described by Waldenström. Calve suggested that it was an arthritis of a subacute or chronic nature; Legg considered it the result of trauma with reduced blood supply; and Perthe postulated an inflammatory origin. In 1911 Phemister showed that it was due to necrosis of bone. He said it was inflammatory and infectious in nature despite the fact that all cultures and guinea pig inoculation tests of the necrotic material were negative. Waldenström, in 1922, described the four distinct stages in the course of the disease, which demonstrated that the degenerative process was followed by regeneration. Reidel in 1922 produced wedge shaped fractures of the epiphysis in test animals. All their femoral heads healed normally without deformity. He concluded then that trauma was not an etiologic factor but postulated that circulatory disturbance caused by bacillary embolism was responsible.

The endocrine system was implicated in 1936 by Cavanaugh, Shelton, and Southerland.[3] In five cases they found a familial history as well as clinical signs of hypothyroidism. Gill,[6] in 1943, published a report of 20 cases of Legg-Perthes' disease which revealed no evidence of thyroid deficiency or pertinent family history of hypothyroidism. He strongly favored aseptic necrosis alone as the cause of Legg-Perthes' disease.

Burrows,[2] in 1941, suggested venous obstruction or hematoma as possible causes. Trueta,[15] in 1957, reported on a study of the blood supply of the femoral capital epiphysis during growth. He found that between the ages of 4 to 7 the only blood supply to the epiphysis is from the lateral epiphyseal vessels, which are branches of the distal part of the medial circumflex artery.

CLINICAL PICTURE

A study of 30 cases assembled from the hospital files and from the files of orthopedists on the staff of St. Joseph Hospital, Paterson, indicates:

*From the Department of Orthopaedic Surgery, St. Joseph Hospital, Paterson, N. J. This paper was read, by invitation, before the New Jersey Orthopaedic Society, October 22, 1960.

Of the 30 patients, 18 were males. In five, the disease was bilateral. Ages varied from 2½ to 8½ years, the median being 5½ years. In males, average age of onset was 6 years; in females the average age of onset was 5.

Six cases had a history of trauma associated with the onset of the disease. The presenting symptoms were either limp or pain, or both. Thirteen had both limp and pain; eight showed pain only; and nine had only the limp. Of the 21 cases with complaints of pain (with or without limp) 17 had hip pain, three had knee pain, and one patient had groin pain.

Duration of symptoms prior to institution of treatment varied from two weeks to eight months. In some, it had been diagnosed many months before admission to the hospital. The stage at which the disease was first recognized and therapy started could not be correlated with the duration of symptoms. One child seen one month after the onset of symptoms had marked degenerative changes; whereas a second patient who had complained of pain and limp for five months showed only very early signs of Perthes' disease upon x-ray. In general, the shorter the duration of symptoms before diagnosis, the less advanced the disease. The very early soft tissue changes of Legg-Perthes' may not appear upon x-ray. Suspected cases should be watched closely, and interval x-ray taken to detect any degenerative change.

PATHOLOGY

THE histopathology has been succintly described by Howorth[9] and Jaffe.[10] The earliest changes occur in the synovium, capsule, and periosteum. The soft tissues become swollen and hyperemic. Microscopically, edema, hypervascularity, and thickening of the synovium membrane with villous formation are the predominant features. Perivascular, lymphocytic and plasma cell infiltration are constant. The distal surface of the epiphyseal plate becomes softened due to decalcification and increased vascularity. The vascularity and edema of the soft tissues decreases, leaving scarring and inelastic tissue, which leads to pannus formation at the margin of the head. As the disease recedes, bone recalcifies; reparation usually begins in the area where degeneration began. The last region to undergo necrosis is the last region to regain normal bone structure.

Four stages characterize the course of Legg-Perthes' disease. In *the initial stage,* which lasts from six months to one year, the soft tissue shows mild changes; the epiphysis undergoes necrosis, while the bone becomes softened. In the *second stage* (the degenerative or fragmentative phase), decomposition of bone occurs, and tissue, profuse in cells resembling connective tissue, invades the necrotic bone. This stage takes one to three years. The *third or reparative stage,* which requires one or two years, commences as the diseased areas of necrotic bone are replaced by granulation tissue and finally by normal bone trabeculae. The *fourth, residual, or definitive stage,* is that in which bone regrowth is completed. The articular cartilage which is nourished by synovial fluid is not degenerated. It has been observed in operative cases in the first or second stage, that the size and shape of the head appears normal. As the disease progresses, the deformity of the head increases and the articular cartilage will eventually become involved and assume the shape of the deformity.

RADIOLOGIC FEATURES

THE histopathologic findings of Legg-Perthes' disease are truly represented on the x-ray. In the *initial* stage of the disease, on occasion, one may see a globular swelling of the capsule due to hyperemia and swelling of the soft tissues. The joint space appears widened on its medial and superior aspects. Evidence of flattening of the head may be noted. Usually, an increase in the density of the epiphysis appears indicating the onset of aseptic necrosis. (Figure 1)

As the disease progresses to the *degenerative stage*, the epiphyseal lines become widened and irregularly calcified. Irregular radiopaque

areas appear in the capital epiphysis. These areas are due to the accumulation of a granular detritus which contains much calcium. (Figure 2) The head becomes wider and flatter. The neck appears shorter and thicker. Lateral erosion of the metaphysis may occur.

The healing or *reparative stage* begins with a decrease in the radiopaque areas, and gradual restoration of the head. Bony trabeculae develop and the proximal portion of the neck becomes convex. (Figure 3)

The residual or *definitive stage* is charac-

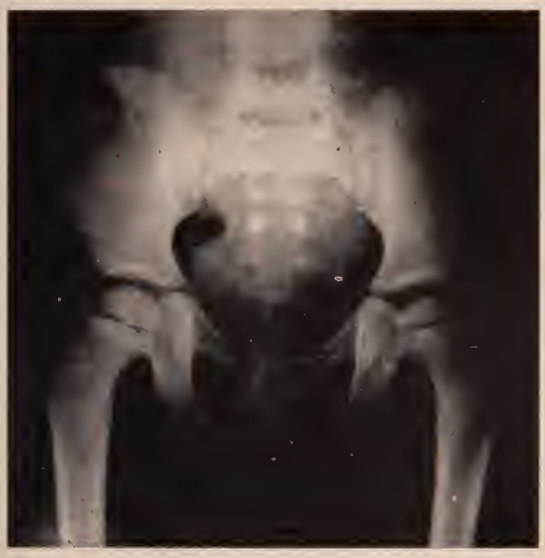


Figure 1: Early Legg-Perthes' of the right hip showing widening of joint spaces and flattening of femoral head.



Figure 3. Early regenerative stage with evidence of normal bone trabeculae.



Figure 2: Degenerative stage showing radiopaque densities of the femoral head, radiolucent areas in the adjacent metaphyseal region, widening of the femoral neck, and flattening of the femoral head.



Figure 4. Definitive stage, demonstrating residual flattening of femoral head and broadening of femoral neck.

terized on the x-ray by the final deformity. Bony trabeculations are normal, and although incongruity of the head may exist, no evidence of active Legg-Perthes' disease remains. (Figure 4).

TREATMENT

THE goal in treatment of Legg-Perthes' disease is to gain a hip joint which has a full range of motion. Radiographically, treatment strives at producing a round head adapted to the acetabulum and approximating as closely as possible the normal.

To obtain this goal the necrotic femoral head must be protected against the mechanical forces of weight-bearing and muscle tension until regeneration is well advanced. To overcome the initial muscle spasm, traction is applied for two or three weeks. Following traction the child is kept on bed rest until regeneration is well advanced. Then the patient is started on crutches and a sling. While on bed rest, he is instructed in exercises; he is allowed to sit but not to kneel. Ambulation with non-weight bearing has been attempted by Pedersen and McCarroll,[14] who treated 54 patients with crutches and a lift on a contralateral shoe. After a nine year follow-up, they concluded that the degree of fragmentation and residual deformity in ambulatory patients was much greater than that observed in patients treated by bed rest and traction. Evans,[5] in a ten year follow-up study of 52 patients, concluded that bed rest was the best means of insuring a good result. Hormone therapy has had little or no effect upon the course of the disease.

Many types of ambulatory devices have been tried. These include crutches and slings, braces, and plaster spicas. Crutches and slings are the most practical. Whenever the sling is used, the patient must be protected against the development of an equinus deformity of the ankle.

The incidence of Legg-Perthes' disease developing in the opposite hip has been reported as high as 25 per cent. Periodic x-rays of *both* hips, therefore, must be taken.

Howorth[9] reported 50 cases of Legg-Perthes' disease treated by a drilling procedure. These drill holes were thought to improve vascularity and to increase the rate of recalcification of the diseased area. Howorth[9] says if the operation is done in the initial stage the residual deformity will be less and the convalescent period will be shortened at least a third of the time normally required. Gill[7] confirmed the impression that drill holes were valuable in the early stages. Pitzen, in 1951, tried a three-edge Collum nail, which he hammered through the epiphyseal plate. He felt this brought about more rapid healing of the epiphysis.

Jonstäter[11] says that surgical intervention in the initial stages of the disease is a valuable adjuvant to therapy. He feels that the benefits derived from such surgical procedures come from initiating regenerative changes as soon as possible and therefore preventing further shrinking of the epiphyseal head. Once shrinkage has occurred in the epiphysis, surgery can no longer improve the final result.

In advanced cases of Perthes' disease associated with subluxation, deformity of the femoral head, and insufficiency of the acetabulum, Gill[7] advises a shelf operation, and Blount, an angulation osteotomy. In some cases relief from pain may only be obtained with an arthrodesis.

The following methods were used in the 30 cases presented in this paper.

Twenty-eight patients had preliminary traction and bed rest. Two were started on weight-bearing braces immediately. Of the 28 in the first group, 11 were placed in spica casts for from 4 to 8 weeks to prevent weight-bearing, reduce muscle spasm, and to accustom these patients to remain in bed. While in bed, these patients were instructed in exercises, were permitted to sit up but were forbidden to kneel. When regeneration of the femoral capital epiphysis was well established, 18 patients were allowed to ambulate with a Sam Browne belt with sling and crutches. Ten were kept on bed rest until regeneration was sufficiently

advanced so that they could safely bear weight on the affected hip. All five patients with bilateral hip disease were treated on bed rest alone. Average length of time between initial treatment and weight-bearing was 2½ years with the range from nine to 42 months.

RESULTS

FOUR of the 30 patient were lost to follow-up. The average length of follow-up was 3¼ years with a range of 1½ to nine years. Results are classed as good, fair or poor. *Good* results are those with complete range of hip joint motion, no shortening, no pain, and little or no residual deformity of the femoral head on x-ray. *Fair* results are those with a complete range of motion, no shortening, no pain, but with a moderate residual deformity of the femoral head. *Poor* results are those either with limitation of motion, pain, shortening and/or marked changes in the femoral head.

There were 21 *good* results; three *fair* results; and two *poor* results. *Poor* results occurred in a patient treated with a weight-bearing brace and in an eight-year old boy who had marked fragmentation of the femoral head when therapy was instituted.

PROGNOSIS

THE prognosis of a case of Legg-Perthes' disease which is diagnosed early and treated with adequate bed rest and non-weight bearing is usually good. Those who come to treatment late, may have a deformity of the femoral head and acetabulum, with the subsequent development of disabling osteo-arthritis. Mindell and Sherman [12] have pointed out that patients treated in the early stages with non-weight bearing had little or no deformity of the femoral head and no significant changes in the neck. In patients in whom therapy was started in the late stages of the disease, the pathologic changes in the femoral head and neck were marked despite the treatment. They found that the younger the patient the better the prognosis. Eyrebrook [4] made a similar observation in his study. Radiographically, the more extensive the change in the femoral neck, the poorer the prognosis. O'Garra [13] stated that patients with changes in the anterior one-half or two-thirds of the femoral head had a better prognosis than those with degenerative changes involving the entire epiphysis.

DIFFERENTIAL DIAGNOSIS

THE following conditions must be considered in making the diagnosis of Legg-Perthes' disease:

(1) Acute transient synovitis of the hip
(2) Rheumatic fever
(3) Avascular necrosis following congenital or traumatic dislocation of the hip
(4) Gaucher's disease
(5) Slipped proximal femoral epiphysis
(6) Tuberculosis of the hip joint
(7) Osteomyelitis of the hip
(8) Suppurative arthritis

SUMMARY

1. The etiology of Legg-Perthes' disease remains undetermined. The work of Trueta[15] indicates that the epiphyseal blood supply from the ages 4 to 7 is dependent upon a single blood vessel. Interference with this tenuous blood supply may well lead to the pathologic process involved in this lesion.

2. The clinical characteristics of 30 cases have been described, along with their roentgenographic features.

3. The treatment of Legg-Perthes' disease is based upon non-weight bearing and protection of the femoral capital epiphysis until reparation is well-advanced.

4. The differential diagnosis has been discussed.

5. Results of treatment have been reported in 30 cases.

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Bibliography will appear in author's reprints.

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Cardiac Arrest with Recovery Following Hypothermia*

After 28 days of coma and a prolonged stoppage of her heart, this patient recovered. Hypothermia was the major factor in this happy result.

A 26-year old woman with a history of pneumonia in 1959, and hemoptysis in 1960, was admitted on March 13, 1960 with a diagnosis of pulmonary tuberculosis with cavitation in the right upper lobe. At the age of 13, she had had hepatitis, probably infectious in type, and an abortion in 1958, followed by curettage.

On admission, there were no abnormal findings, except for abdominal tenderness in the right and left lower quadrants. She was placed on streptomycin, 1 Gram every third day, and PAS, 12 Grams daily. Response was excellent, but in October 1960, it was noticed that a small cavity still remained and there was no tendency to closure. A consultant suggested surgery for segmental or possible right upper lobe lobectomy. The latter was scheduled for October 19, 1960. Physical examination one day prior to surgery, as well as preoperative laboratory findings, were well within normal limits.

SURGERY

The operative procedure under thiopental and cyclopropane with endotracheal anesthesia started at 8:20 a.m., on October 19, 1960. Resection of the right upper lobe was done. There was little bleeding, with only 200 cubic centimeters of measured blood loss at the termination of the lung resection. Towards the end of the operation, the anesthetist was unable to obtain the patient's pulse and blood pressure. The chest was then reopened and the heart was found in standstill. After 90 seconds of vigorous massage with one hand, the heart beat was restored. This beat was feeble at first, and massage was continued. Soon the peripheral pulse could be felt without massage. The massage was discontinued after waiting for 15 minutes to see if the condition was relatively stable. Then the chest was reclosed. The exact length of time of cardiac arrest in this case is unknown. Following the chest closure, Neosynephrine® and Levophed® were used to maintain the patient's blood pressure in the 100 systolic range. Doctors and nurses were assigned to stay with this patient around the clock. She remained unconscious and hypothermia was attempted several times, beginning 12 hours postoperatively (October 19, 1960, at 10:00 p.m., and again on October 20, 1960, at 3:00 a.m.), but each time the patient had severe tachycardia and hypotension, and the hypothermia was discontinued. Successful hypothermia below 95 degrees Fahrenheit, was finally instituted about 24 hours postoperatively, with the use of thiopental and promethazine to control the shivering. The

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cardioscope had been instiuted immediately post-surgery.

OBSERVATIONS

We divided the consequent period into two major phases; unconscious (or comatose) period; and conscious period. The *unconscious* or comatose period lasted for 28 days. This was from the time of operation to the last day of deep coma, during which time, hypothermia was applied for 96 hours, approximately 24 hours after the cardiac arrest. The *conscious* period included observation for 95 days. This was from the day of slight response to spoken word, to the day of discharge with full consciousness and ambulatory status as a normal person, except for a mild ataxia. This included a 32-day period before she started to walk and 63-day period from walking to discharge from the hospital upon completion of observation.

HYPOTHERMIA

We used four blankets in which iced water was circulated through many channels by means of a water pump. This "thermoblanket" system was applied on the trunk and all extremities. An electric thermometer was retained in the rectum for constant temperature readings. A cardioscope with monitor was also attached to the patient throughout the period of hypothermia. The temperature was difficult to control, because of wide range of "drifting" after the iced water was turned on or off. Room temperature was kept between 55 and 65 Fahrenheit. During this four-day period, the blood pressure was maintained between 68 and 98 systolic. Diastolic pressure was almost imperceptible. Heart beats were regular with sinus rhythm rating between 90 and 120 per minute. There was one occasion of arrhythmia on the first day when the temperature went down to 91. She had frequent premature ventricular beats which disappeared with slight elevation of temperature. The distal portions of extremities showed only a moderate degree of cyanosis, but frostbite or gangrene did not develop. Respiration was quiet and of normal rate. Oxygen (by nasal catheter) was continuously given at a low range. Serial studies of chest x-rays did not show anything unusual. Indeed, there was evidence of good expansion of the operated side of the lung. Nourishment consisted of parenteral fluid with a daily average of 2½ liters. Urinary output averaged 2000 cubic centimeters a day. The parenteral fluid consisted of 5 per cent dextrose solution with electrolytes added. Hematology and blood chemistry were within normal limits. Specific gravity of urine was between 1.004 and 1.012, free of sugar and albumin.

NEUROLOGIC FINDINGS

The patient remained in coma continuously from surgery with only mild hypertonus of musculature following deep supraorbital pressure and painful stimulus. This appeared bilaterally and was easily overcome by passive movements. Her pupils were in mild dilatation, the left slightly larger. Both pupils were sluggishly active to light, or inactive. The corneal reflex was present. Optic vessels and discs were normal, but there was a small flame hemorrhage in the temporal side of the left disc. Brain stem distributor reactions showed an ocular movement with head rotation. No nuchal rigidity was found. Deep tendon reflexes were sluggish but equal. Bilateral Babinski was present after the cardiac arrest for a few days. She had a typical picture of hypoxic ischemia of the brain stem affecting the reticular formation with loss of consciousness and bilateral pyramidal involvement. This was not different from the picture seen in serious intracranial injuries and other forms of cerebral ischemia. We, therefore, considered the prognosis for Life to be poor, expecting many types of neurologic damage and other complications.

OTHER MEDICATION

Other supportive measures were: administration of vasoconstrictors, sedatives, anti-

biotics, and digitalis. No hypertonic glucose solution or human serum albumin was tried in order to relieve the cerebral edema in this period.

PERIOD FOLLOWING HYPOTHERMIA

After 96 hours, the hypothermia was discontinued. It took nine hours to lift her temperature from 93 Fahrenheit to normal. The temperature then fluctuated between 101 and 105. At the end of this unconscious period, her temperature was gradually declining. Her cardiovascular system was within normal limits except for sinus tachycardia and a digitalis effect evidenced by electrocardiogram. Discontinuation of hypothermia caused the patient to become restless. Within 24 hours she was having convulsive-like movements of the body with opisthotonus and difficulty in breathing, resulting in cyanosis. A tracheotomy was then done. Nourishment was given through a gastric tube. To combat cerebral edema, hypertonic glucose solutions and human serum albumin were tried for several days. At the end of this comatose period, the restlessness of the patient reached a maximum for a few days. Then, consciousness returned.

CONSCIOUS PERIOD

Early Stage: 32 days. This period was arbitrarily set from the day of slight response to spoken words, to the day before starting to walk. Following maximum restlessness for a few days, she became suddenly quiet and at the same time began to respond to spoken command. This change was quick and obvious. She was trying to turn her face towards the direction from which the sound was coming. She was more responsive to German words than to English (she had been born in Germany). She smiled, although it was doubtful if she understood the meaning of the spoken words. She did not seem to see objects nor was she able to follow them. After this remarkably sudden change on the first day of this period, her neurologic and other status showed steady improvement day by day, although she was restless until the sixth day of this period. By the 13th day of this period, the patient was able to sit up for a long time and to hold a glass of water in her hand and drink some of it. At this time coordination of muscles was remarkably impaired. Soon she began to understand simple words and her voluntary motions were improved. By the 15th day of this period, increased improvement was visible in her response to cold temperature in her room, changes in facial expression, reasonableness, returned ability to speak simple words, although the words were markedly slurred. She was also able to recognize people whom she had known prior to surgery. By the end of this period, the expression of her face became almost like that of a normal person. Coordination of muscles became more improved. Ambulation on the wheelchair was then gradually started. Her vision, however, was blurred.

Late Stage: 63 days. This stage included the period from the day of starting to walk to the day of discharge from the hospital. Only a mild ataxia was then present.

NEUROLOGIC STATUS ON DISCHARGE

The patient appeared well nourished, alert and cooperative. She was speaking in a monotonous drawl. Her speech was somewhat staccato. Cranial nerves were normal, except for a small quadrantal defect at the inferior temporal optic discs. The optic discs were clear and ocular movements without nystagmus, but showed a lag upon looking to right and left. Pupils were active and equal. Hearing was normal. She walked with a wide stance and showed mildly ataxic gait. She swayed in the Romberg position. Mild incoordination on the left was noted on finger-to-nose and finger-to-finger tests. All deep reflexes were sluggish but equal. No pathologic reflexes were found on plantar stimulation. She had good power in all extremities in individual muscle testing. Sensory examination showed mild discrimination of vibratory perception in lower extremities and mild astereognosis; but gross

modalities were otherwise normal. Her ataxia was probably of cerebellar origin, involving only the left side. Electroencephalogram showed only mild dysrhythmia, with a borderline tracing, suggestive of a diffuse disturbance.

COMMENT

DRAMATIC change following cardiac arrest is the result of injury to central nervous system due to hypoxia or anoxia. This is usually followed by destruction of nerve cells and cerebral edema. Hypothermia is an effective method for these neurologically affected patients. Williams and Spencer [1] reported recovery of 3 out of 12 cardiac arrest cases *without* hypothermia; and recovery of 10 out of 12 *with* hypothermia. These were in dogs where body temperature was maintained between 89 and 94 Fahrenheit for 18 to 36 hours. Feldman and his colleagues [3] reported a complete neurologic recovery following hypothermia, in a child.

In interpreting the effect of hypothermia, we are confronted with two difficult factors: (1) poor understanding of the pathologic change of the brain; and (2) insufficient material to reach a conclusion. Hypothermia is said to produce normal brain volume and to protect the brain against anoxic injury. This protection appears related to the demonstrable reduction in cerebral consumption and cerebral blood flow in hypothermic individuals.

In the case here reported, the duration of cardiac arrest was unknown, but the heart was eventually resuscitated after manual massage for 90 seconds. This patient's cardiac arrest was followed by a deep coma which continued for 28 days. Hypothermia was applied for the first 96 hours. Duration of this patient's coma is one of the longest so far reported. Yet, after this long period, her neurologic recovery was gratifying and eventually reached the point where she could act as an almost normal person. The patient was discharged at her own request, after 123 days of observation.

As a result of our clinical experience and a review of the literature, we feel hypothermia was worth trying on this patient. Other supportive measures including control of her body chemistry and physiology in this period were important in the restoration of her neurologic status.

SUMMARY

A RECOVERY of a 26-year old woman who had a cardiac arrest in the course of pulmonary resection is reported. Hypothermia was begun 24 hours after this accident and continued for 96 hours. Temperature was kept between 91 and 95 Fahrenheit.

After a 28-day period of coma, she began to respond to spoken words, and after 32 consecutive days, she started to walk. After 123 days of observation, this patient was discharged, normal except for a mild ataxia and a slight speech defect.

The John E. Runnells Hospital for Chest Diseases

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Some Practical Thoughts Concerning the Aged

Rising rates of delinquency and venality bring heartache to grandparents too. As Dr. Nitshe here points out, the family physician has an interest in all this.

Much is written today about the pleasant outlook for aged folk due to the progress of medicine, hygiene, nutrition and sociology. Any number of programs have been instituted by our national government all the way down to the smallest borough unit to advance their welfare. We give so much consideration to their medical needs, to their physical welfare, and to their psychic enhancement through recreational and rehabilitation programs that to grow old quickly seems to be the best possible thing for any young person today. On every turn of the road some opportunity will exist. The cost of medical care will be lower or totally underwritten by the State, a measure of tax relief will be afforded them, even special housing may be available. Apples of gold are within their reach. But is this so? Are they really happy? Let us think just a bit and evaluate.

Their children, or grandchildren, have provided us with the highest crime rate of any civilized country. More juveniles are delinquent than ever before. The divorce rate has soared beyond anything that was ever known in pagan Rome. In some areas, illegitimate and legitimate births vie with each other. In spite of excellent chemotherapy, venereal disease is on the march. This truly is a bewildering state of affairs!

Are we so blind as to believe that this state of things, which (in part or in the whole) invades so many families, builds contentment and a sense of well-being? Can a relief appropriation or a social agency comfort the heartache caused by a delinquent son or daughter?

It is natural for an aging parent to reflect upon his life. Nothing is more gratifying to such a one than the success of offspring. Success, however, is never properly measured by monetary terms or position. The aging parent looking at a daughter with a good job and a new car but who has just come home with an illegitimate set of twins has very little over which to rejoice. The grandfather of a juvenile gang leader certainly must have reasonable concern about the integrity of his son or daughter-in-law who raised such a child.

All of this is relevant to medicine. Patients who are unhappy and insecure visit physicians more often for complaints than do those who have equanimity. The arthritis or the angina that just would not bother the composed individual, may become unbearable in the sorrowing one. And there seems to be something about basically unhappy individuals that as old age comes upon them gives way to a lack of desire to live. No physician minimizes the problems involved in the attending of these patients.

When oldsters in a strife-ridden family be-

come ill and are incapacitated, what really does happen to them? If they are acutely ill adequate hospitalization will be provided. Many, however, just need "tender loving care" over a crucial period. Assistance from any agency or institution no matter how well directed never can equal that which is properly administered from one's own kith and kin. Mildly incapacitated folk do best in a home environment with an understanding mate or offspring. An individual who has maladjusted children or grandchildren, consciously or unconsciously does not look forward to a pleasant sojourn in their presence. A person who is socially offensive towards the public is really no different at home. Old folk (and people in general) *know* when they are wanted and when they are loved. We often find a parent needing help that no agency or institution could ever offer, who has four or five children he has raised to maturity and self-subsistence. All are employed or have marital obligations. They will not participate in giving personal attention. These children are as guilty of malconduct as though they were involved in some chargeable crime. Indeed, in the past, some have been involved in juvenile problems and gross marital difficulties and their present irresponsibility is just a further example of a basic lack. When parents are cared for by those who are unwilling to do so, they may be neglected in subtle ways. Their environment may appear to be adequate in a general way, but the basic love and encouragement they should receive is lacking. Many old folk need to be encouraged and coaxed to eat, and to eat properly. Hydration must be maintained. They need to be induced to be active and not to seclude themselves. Just because there has been a stool does not mean that it has been an adequate one. Fecal impactions are common. A rectal examination should be done to detect an impaction; and even then one may be present but not found by the examining finger and so purgatives should be given if the physician has any suspicion of inadequate bowel action. Some notation should then be made by some responsible individual as to the character of the stool that resulted, and a further digital examination of the rectum should be made, at which time, perhaps, a hard fecal concretion may be noted. Because of the frequent lack of concern of those who send reports, it is incumbent upon the physician that he assiduously inquire as to how much fluid and how much food the individual consumes in a day, and whether he retains it. Inquiry should be directed as to the quantity of stool and as to whether it is formed or soft —the latter being frequently found in the presence of impaction. The quantity and frequency of urine passed also should be noted. Periodic examination should be made of the abdomen to detect if there is any distention, particularly of the urinary bladder.

Occasionally the physician may find himself faced with a family who cares for the aged parent with just enough interest to keep him alive. Their idea is that he is old and that "he can't get well." They will help a little bit and "let nature take its course." The doctor is supposed to do a minimum for him so that he will not "prolong the suffering." This family does not really want the responsibility that is properly theirs and they are rationalizing themselves out of their predicament. It then becomes the delicate duty of the physician to force good therapeutics upon that family. He should make whatever number of calls are necessary, irrespective of their interest or desire to remunerate him. The patient should be hospitalized if this is the best procedure. If he is kept at home the physician should satisfy himself that that patient is receiving adequate care. If there is a serious fluid deficit, feeding *via* an intranasal tube should be instituted. This is possible at home, and very little supervision is needed. It offers the advantage of ease of alimentation. Many medications can advantageously be given *via* the tube, and liquid vitamin supplements may be easily added. Because of the decline of family responsibility, today's physician has problems unknown in his father's time.

If our general trend continues in the lowering of our standards of morality (measured

by the alarming increase of crime, delinquency, illegitimacy and venereal disease) it would seem that the plight of our aging population will become more involved and serious, despite legislative efforts. There was a time when it was felt that it was wise to train a child in the way he should go. The hope was that when he was old he would not depart from it. But this has been neglected by many and a harvest of sorrow is being reaped. The future for our old folk is not as bright as it seems in this age of social reform. In the final analysis it is questionable if an oldster has any more to look forward to than that which he has actually personally provided for himself. The old truth of "what a man soweth, that shall he also reap" still holds good for this day, and it will for eternity.

Providence Farm

Adolescent Suicides in Sweden

Writing in Stockholm's *Acta Paediata* (51:17, January 1962), C. Bergstrand and U. U. Otto offer case notes on patients under 21 years of age who had been treated because of attempted suicide. Data were requested from 471 hospitals in Sweden, and 465 of the hospitals furnished the information. After the case material had been checked for duplication there remained 1,727 for the 5-year period 1955 to 1959. Of this number 351 were males and 1,376 were females. It was established that frequency of suicidal attempts increased with age. The majority of the patients (83 per cent) belong to the low income group. Investigation of the reasons for the suicidal attempts revealed love problems to be the most frequent cause (30 per cent). Disturbed home conditions, caused by alcoholism or mental disturbances in the parents, or by broken homes, were the reason for the suicidal attempt in 25 per cent of the cases. Girls were in the majority in these 2 groups. Boys constituted a large percentage of the group who had school problems, and they were in the majority in the group with mental disorders (neuroses, psychoses, and character disorders). In the absence of a thorough psychiatric examination it proved difficult to ascertain the cause of the suicidal attempt. Ingestion of drugs accounted for 87 per cent of the suicidal attempts. More violent methods and repeated attempts were observed chiefly in boys, and boys more often required continued psychiatric treatment than did the girls.

Encephalitis in New Jersey

Writing in the January 1962 *American Journal of Tropical Medicine*, R. O. Hayes and colleagues report on the 1959 epidemic and epizootic of eastern ecephalitis (EE) in New Jersey. Extremely heavy rainfall during July resulted in a record production of mosquitoes, the three most abundant species being *Aedes sollicitans, Aedes vexans,* and *Culiseta melanura.* Change in the average wind direction from southwest to south probably increased the contact of salt marsh mosquitoes with humans in the epidemic area. A serum survey of 22 farm chicken flocks indicated that about two-thirds had hemagglutination inhibition (HAI) antibodies to EE and that high rates of EE transmission occurred in both the coastal and inland areas of southern New Jersey. About one-third of 92 wild bird serums also had HAI antibodies to EE. All available information supports the hypothesis that: (1) The swamp mosquito, *C. melanura,* served as the primary sylvan vector which carried EE virus from enzootic swamp foci to peridomestic wild and domestic avian reservoir hosts in both the epidemic (coastal) and epizootic (inland) areas; (2) *A. Sollictans* served as the primary epidemic vector in the coastal area where most of the human cases occurred, obtaining its infection from peridomestic avain hosts (including chickens) and subsequently transmitting the infection to man; (3) *A. vexans* served as the primary epizootic vector in the inland areas of the equine outbreak.

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Post Mortem Cesarean Section*

When a woman in labor or late pregnancy dies suddenly, the physician is faced with an awful responsibility demanding quick thinking. Doctors Biondo and Cacciarelli have one answer: do a postmortem and try to save the baby.

Although postmortem cesarean section is not new, each time it occurs it causes excitement, and, if a live baby is delivered, it brings a reward to the physician. Dealing with young people, we obstetricians are not as accustomed to sudden death as are practitioners in some other branches of medicine. But, because of the nature of obstetrics, we are geared to handle emergencies. In no emergency situation is such clear thinking and rapid action imperative as in the case of a gravid patient who expires suddenly or who faces imminent death. Infant survival then depends upon four factors: (1) the time element; (2) cause of maternal death; (3) available facilities; and (4) the human element.

Time Element: Maximum time between maternal death and infant survival has not been precisely determined. Many authorities say that twenty minutes is the longest time an infant can survive after the death of the mother. There are no authenticated cases on record to dispute this time limit.[1]

Cause of Maternal Death: The literature lists the following dozen causes of maternal death: Blood dyscrasias, amniotic fluid embolism, severe toxemia, rupture of dissecting aortic aneurysm, pneumonia, malignancies, long continued infections, bulbar poliomyelitis, tuberculosis, cardiac disease and spinal anesthesia. We agree with Lattuada[2] that fetal prognosis is better in sudden and rapid death of the mother than in the diseases here listed

Facilities: Postmortem cesarean section with infant survival has been accomplished through the centuries, even by laymen. We, therefore, cannot accept the excuse that a hospital does not have personnel or equipment to handle such emergencies. The physician in charge of the obstetrical ward should certainly have special training in the resuscitation of hypoxic infants.

The Human Element: Even the most experienced physician, confronted with this unusual situation, may have difficulty in deciding his course of action. His problem may be complicated by religious, moral and legal considerations. A rapid decision coupled with a knowledge of the surgical procedure and of effective methods of infant resuscitation is needed—and is expected.

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*Presented June 30, 1961 at the New Jersey Obstetrical and Gynecological Society. Dr. Biondo was Chief Resident in Obstetrics and Gynecology at the Harrison S. Martland Medical Center in Newark and Dr. Cacciarelli is an intern there.

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THE chance of infant survival is immeasurably aided by the infant's own specialized adaptive mechanisms. Prystowsky[3] states that a 50 per cent oxygen saturation can be produced in the blood of a fetus near term with an oxygen pressure of only 19 millimeters of mercury whereas the blood of a pregnant woman near term requires an oxygen pressure of about 25 millimeters of mercury to be similarly saturated. During pregnancy, the fetus *in utero* is in a state of hypoxia due to the oxygen pressure gradient, that being equivalent to 35 or 40 millimeters of mercury or approximately one-third that of the adult oxygen pressure of 100 millimeters of mercury. More recent observations[4] of fetal oxygenation in maternal hypotension, pre-eclampsia and abruptio placenta show the gradient to be reduced to approximately one-half that found in a normal pregnancy.

The fetus *in utero* is, however, able to adapt to this state of hypoxia presumably because of its special type of "fetal" hemoglobin which gives off oxygen more readily than does the adult type of hemoglobin. Adaptation is further accomplished by other differences in the fetal blood such as: 20 per cent more hemoglobin than the adult, an average of 17 Grams per 100 cubic centimeters; and other evidence of increased bone marrow activity—nucleated red blood cells, polychromatophilia, anisocytosis and poikilocytosis. These special adaptive mechanisms are found to disappear[5] during the first few weeks of extrauterine life.

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A 36-year old gravida 3, para 2, female, 38 weeks pregnant, was brought to the receiving room of Martland Medical Center at 3:00 a.m. on November 30, 1960 and was pronounced dead on arrival. No history of the pregnancy was available. Just prior to her arrival at our hospital, the patient was found wandering in the streets apparently gasping for air. On her two previous admissions to Martland Medical Center for delivery in 1952 and 1953, her blood pressure ranged from 140/90 to 260/140.

Death probably had occurred a few minutes prior to her arrival. The admitting physician notified the obstetrical resident who, within three minutes, reached the receiving room and performed an emergency cesarean section. A five-pound six ounce well developed female infant was delivered at 3:10 a.m. No abnormalities were noted either in the uterus or in the amniotic fluid.

The infant was cyanotic at birth with extreme flaccidity of all musculature. She exhibited no respiratory efforts, and was immediately intubated and kept warm with hot sheets. The fetal heart tones, weak initially, improved with intermittent positive pressure resuscitation and respirations commenced after approximately ten minutes. The baby was placed in an incubator and transferred to the Premature Unit where her respiration became normal and muscle tone improved. Progressive improvement was noted until the infant's discharge from the hospital. The baby, now eight months old, is reported by her foster parents as developing normally.

Maternal Autopsy: Pertinent findings were: a markedly hypertrophied heart, the right ventricular wall measuring ¼ inch and the left wall measuring one inch. The lungs exhibited marked edema and congestion, the bronchial mucosa being congested with frothy edema in the airway. The uterus was 10 inches by 6.5 inches by 2.5 inches, its anterior surface covered with placenta 7 inches by 6 inches by ¾ inch; the cervix admitted one finger. A diagnosis of congestive heart failure with hypertensive cardiovascular disease was made by our medical examiner.

CONCLUSION

ON THE basis of our personal experience and recent reports of postmortem cesarean section with infant survival, we feel justified in encouraging the procedure. This is a personal decision, to be made quickly. But as physicians, we are obligated to try to salvage the life of an unborn child.

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Evaluation of Bendroflumethiazide in General Practice

The search for the ideal diuretic continues. If Doctor Bernell's observations are confirmed by subsequent studies, it would appear that bendroflumethiazide is an effective and safe diuretic for long-term use.

ALTHOUGH every physician is concerned with the safety and the efficacy of the medications he prescribes, general practitioners, who usually cannot hold their patients under constant supervision, are particularly dependent on the drugs they administer fulfilling an expected purpose without eliciting undesirable effects. The present report describes the extended trial of bendroflumethiazide, one of the newest and most potent of the orally administered diuretics presently available. Bendroflumethiazide was given over a period of 14 to 17 months in some patients with complete safety and with no loss in diuretic activity. Some of the more significant observations made during the study are given below.

THE PATIENTS

THE 50 patients in this series included 29 females; the males ranged in age from 20 to 74 years and the females from 10 to 81. Omitting the 11 females with dysmenorrhea, 8 of the remaining 18 females were over 50 years of age; 15 of the 21 males were over 50 years old. Twenty-four subjects had edema, usually related to cardiac problems; 11 had menstrual disturbances; and 15 were severely or moderately hypertensive. About one-half of the entire group was overweight. Concomitant ailments included gouty arthritis, diabetes mellitus, thyroid disorders, urinary tract disease, and silicotic pneumonia.

Nineteen of the 50 patients had previously been treated with chlorothiazide, hydrochlorothiazide or other diuretics, but had been forced to discontinue these agents because of acutely unpleasant reactions. Methychlothiazide had been tried and found ineffective in one patient. A number of patients had previously received Rauwolfia serpentina whole root, with only limited improvement.

Of the 11 patients with dysmenorrhea, 2 had severe migraine with nausea and vomiting, 2 had varicose veins, and 1 presented edema of the legs and pyelonephritis. Five were obese, 2 of this group weighing 210 and 214 pounds, respectively.

Eight of the 15 patients with hypertension were severely ill, with initial diastolic pressures of 120 or higher. The remaining 7 were moderately ill, with diastolic pressures between 108 and 118.

THE MEDICATION

THIRTY-NINE of the 50 patients were initially given 5 milligrams of bendroflumethiazide*

*Supplied as Naturetin® by Dr. B. M. Wimer of the Squibb Institute for Medical Research, New Brunswick, New Jersey.

2 or 3 times daily until improvement was evident, and were maintained thereafter on 5 milligrams once daily. Nineteen of the 39 patients were treated for 10 months or longer and all but 5 of the 39 patients had been treated for more than 3 months at the time of report.

The 11 patients with dysmenorrhea were instructed to take 5 milligrams of bendroflumethiazide daily for one week preceding their menses and 5 milligrams twice daily during their periods.

Fourteen patients (12 with hypertensive disease and 2 with coronary heart disease) received Rauwolfia serpentina whole root (Raudixin®) concurrently with bendroflumethiazide. The initial dose of rauwolfia was 200 milligrams daily, but the maintenance dose was 100 milligrams per day. Nineteen patients with myocardial insufficiency or failure were also medicated with digitalis or digitoxin. Other drugs prescribed for specific conditions presented by selected patients included tolbutamide, benzphetamine, dextroamphetamine, diethylpropion, probenecid, meprobamate, penicillin, and demethylchlortetracycline.

RESULTS

IN edematous states, the edema disappeared entirely after treatment or was markedly reduced in amount in the legs and lungs of all 24 patients presenting the condition. Abatement of edema was frequently accompanied by striking losses in weight. Weight loss (ranging from 18 pounds in 10 weeks to 75 pounds in one year) was especially conspicuous among the 7 patients with varicose veins. All of these had been notably obese before treatment.

In dysmenorrhea, all eleven patients experienced complete relief or substantial diminution of the symptoms presented. Migraine and nausea were well controlled and the tension, edema, and pressure and heaviness in the lower pelvis subsided. All have been able to continue normal activity throughout their periods since receiving bendroflumethiazide. Four of the patients have lost much weight: one lost 18 pounds in 10 weeks and the other three lost from 30 to 40 pounds within one year.

In hypertension, all 15 patients with hypertension manifested a favorable response to treatment with bendroflumethiazide, as judged by reductions in both mean and diastolic blood pressure. The mean blood pressure† fell at least 20 millimeters in every patient. A fall of 10 millimeters or more in diastolic pressure occurred in every patient but one. The fall in diastolic pressure exceeded 20 in 8 patients, was between 10 and 20 millimeters in 6; and 8 millimeters in the remaining patient. Six patients attained "normal" blood pressure (150/100 or less).

Bendroflumethiazide and Rauwolfia serpentina whole root (Raudixin®) were given concomitantly to 12 of the 16 hypertensive patients. Some of these 12 patients had previously been on rauwolfia alone, but a more satisfactory response occurred after the benzothiadiazine was added to the regimen.

UNDESIRABLE EFFECTS

THE only unfavorable reaction to appear durduring the entire course of treatment was dryness of the mouth. This side effect was reported by 19 of the 50 patients. Even among the 24 patients who received bendroflumethiazide for 10 months or more, none experienced any ill effects other than occasional dryness of the mouth. The 19 patients who could not tolerate chlorothiazide, hydrochlorothiazide or other oral diuretics were able to take bendroflumethiazide with complete comfort. No clinical signs of hypokalemia were discernible in any patient, even among the 19 who were taking digitalis concurrently.

Four patients with diabetes mellitus, who were under treatment for from 9 to 12 months, and 2 with gouty arthritis, under treatment for 10 to 12 months, tolerated the medication well, with no exacerbation of their disease.

†Mean blood pressure is midway between diastolic and systolic pressure.

DISCUSSION

THIS investigation confirms previously published reports[1] on the excellent diuretic activity[2,3] and antihypertensive effects[4,5] of bendroflumethiazide, and indicates that favorable responses to bendroflumethiazide may be continued during periods of treatment extending over many (10 to 17) months. The study also indicates that bendroflumethiazide is well tolerated for long periods of treatment, even when it is substituted for other thiazide preparations which were poorly tolerated. Occasionally untoward effects such as allergic reactions, leg cramps, pruritus, skin rash, and gastrointestinal disorders have been reported by previous investigators; but, in the author's experience, the only unwanted effect was dryness of the mouth, reported by 19 of the 50 patients in the present series.

SUMMARY

1. A series of 50 patients has been treated with bendroflumethiazide. Treatment was continued in 24 of the group for periods of 10 to 17 months.

2. Of 24 patients with heart disease (arteriosclerotic, rheumatic, coronary, or congenital), or with varicose veins, a good effect was seen in all; edema of the legs being reduced and fluid disappearing from the lungs of most patients.

3. In a series of 7 with varicose veins, an average weight loss of 37 pounds was recorded during treatment for periods up to 14 months.

4. Eleven patients with dysmenorrhea also responded to bendroflumethiazide, the drug being given for a week prior to and for 5 days during menses. Premenstrual tension and migraine headache reported by some in the group, were relieved after bendroflumethiazide was administered.

5. All of the 15 patients with hypertension responded to therapy. To 12 of these individuals, Rauwolfia serpentina (whole root) was given simultaneously. Treatment was given for at least 3 months to all patients and for as long as 15 months in one instance. Except for dryness of the mouth (usually slight), which occurred in 19 of the group, no unwanted reactions were seen in any patient.

6. Bendroflumethiazide appears to retain its effectiveness when given continuously for periods of many months to patients with disorders characterized by the presence of edema and hypertension.

RESULTS IN 50 PATIENTS TREATED WITH NATURETIN®

Condition Treated	Number of Patients	Age Range (years)	Treatment Dosage (mg./day)	Treatment Duration (months)	Results Good	Results Poor
Edematous states	24	10-74	5-15	2-17	24	0
Dysmenorrhea	11	17-41	5-10	5	11	0
Hypertension	15	34-81	5-15	2-12	15	0

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1300 Princess Avenue

Introduction of the New President*

Joseph A. Lepree, M.D., Elizabeth

Mr. President, Officers and members of The Medical Society of New Jersey, Distinguished Guests, Ladies and Gentlemen:

It is my great privilege to have been accorded the honor of presenting to this distinguished assembly the 170th president of The Medical Society of New Jersey—Dr. Louis Stanley Wegryn.

I shall not presume to introduce Doctor Wegryn to you, because I realize that it is in consequence of your having known him so long and so well that you have chosen him for the high office which he now assumes.

Presenting him, I shall briefly supply the fundamental data of his life and the highlights of his professional career that they may be in your minds as you welcome him to his new position as president of this great and distinguished Society.

Louis Stanley Wegryn was born in Elizabeth, New Jersey, on January 4, 1903, the second of eleven children, of whom seven now survive. His elementary and secondary school education he received in Elizabeth where as an ambitious and industrious boy and young man he contributed to the family's finances by working first as a newsboy and later as a day-laborer. In September of 1921 he entered the University of Illinois in the premedical program, providing for his maintenance as a dishwasher. Later, having acquired the degree of bachelor of science, he entered the School of Medicine of the University of Il'inois, supporting himself by doing janitorial work. He received his degree as Doctor of Medicine in 1927. Following graduation, he interned at the St. Louis City Hospital, St. Louis, Missouri.

In 1928 he married Edna Mae Pennington of Desloge, Missouri. Their union was blessed with three children: Stanley, who is a Doctor of Medicine specializing in gynecology and presently practicing in Elizabeth; Barbara—Mrs. Alfonso Marroquin—who resides in Madrid; and Robert, who is presently a junior at Cornell Medical School. Doctor and Mrs. Wegryn are the proud grandparents of Heidi and Tara, children of Doctor and Mrs. Stanley Wegryn; and of Kevin, son of Mr. and Mrs. Robert Wegryn.

Doctor Wegryn is a past-president of the Association of American Physicians and Surgeons, of the Union County Medical Society, and of the International Academy of Proctology; and contributing editor of the *American Journal of Proctology*. A former police commissioner of Elizabeth, Doctor Wegryn is a director of Alexian Brothers Hospital Foundation and of the Elizabeth Federal Savings and Loan Association.

Doctor Wegryn is a Fellow of the American College of Surgeons, of the International College of Surgeons, of the International Academy of Proctology, and of the Academy of Medicine of New Jersey. He is an Associate Fellow of the American College of Gastroenterology. Doctor Wegryn holds membership in the American Medical Association, the Union County Medical Society, the Society of Surgeons of New Jersey, the American Board of Abdominal Surgery, and the Phi Rho Sigma Medical Fraternity. He is also a member of the Elks (B.P.O.E. No. 289), the Elizabeth Lions Club, the Knights of Columbus, the Association of Reserve Officers of the United States Public Health Service, and the World Medical Association.

During his 34 years of practice—which he entered as a general practitioner and in which he subsequently adopted the specialty of surgery—Doctor Wegryn has won the esteem and respect of a tremendous group of patients, many of whom have become his closest friends and he their confident.

In the course of the years, time and again the city fathers have sought his advice in con-

*Remarks made May 14, 1962 at the Annual Meeting.

junction with the rapid growth of the industrial city of Elizabeth. He served on the first housing commission of that city.

Doctor Wegryn is a man of marked ability, integrity, industry, generosity, and unselfish dedication. His sincerity shines through all that he does. His capacity for constructive endeavor is the marvel of all who know him. He will, I am sure, give to The Medical Society of New Jersey a record of service that will long be remembered with pride and gratefulness.

Ladies and gentlemen, it is my great personal pleasure to present to you at this time the 170th president of The Medical Society of New Jersey, Dr. Louis Stanley Wegryn.

Address of Retiring President*

Ralph M. L. Buchanan, M.D., Phillipsburg

Officers and Delegates, Members of The Medical Society of New Jersey, and Ladies and Gentlemen!

I suppose that it is natural as one retires from the presidency to wish that one could report that all the affairs of the Society are serenely in order and that there are no problems or difficulties confronting it. That, however, is a wish that certainly has not been fulfilled for me.

I am sure that you will all recognize and appreciate that our Society is exposed—on many sides—to circumstances which its officers and members, no matter how diligent and vigorous their efforts, cannot control.

Moreover, the activities and problems of an organization such as ours are continuous and progressive. So the president who takes his leave of a society such as ours is like a motorman who surrenders his place at the controls to another and waits for a later moment, when the forward motion will be checked sufficiently to permit him to leave the moving vehicle, unnoticed and in safety.

That's the position in which I find myself today. I have very much enjoyed the run. I tried to make it smooth and satisfying. I am now ready to turn the controls over to my elected successor, and then I shall fade back to rest and relative inaction.

I am profoundly grateful for the honor of serving as the President of The Medical Society of New Jersey. From the bottom of my heart, I thank all who advanced me to the office and all who assisted me in dealing with the business of the Society through my term of office.

In my inaugural address I expressed myself as of the opinion that as members of the medical profession and as citizens we had a war to wage. That war is still raging, and the tempo of its action shows no sign of diminishing. Our position is still one of real peril. The question is—in view of the drive to overwhelm us, "Can we survive and live as free men?"

We are convinced that if America is true to her philosophy and traditions, if the Constitution still stands, if justice and freedom are preserved, then we can survive and so live.

We are fighting, therefore, to keep America true to her philosophy and her traditions; and, thus, true to herself and her citizens. We are fighting for the retention of the spirit and letter of the federal Constitution and the rights of individuals, which it guarantees and safeguards. We are fighting for the continued recognition and retention of justice and freedom as fundamentals in the lives of all Americans . . . these are the things that—as members of the profession of medicine and as citizens of the United States—we live for. These are the things that—as members of the profession of medicine and as citizens of the United States—we are ready, if necessary, to die for.

Closing my inaugural address, I said: "In such a war, for such a cause, waged in such a spirit, it is almost a pleasure to fight. I am happy to be in it with you." As your ex-President, these sentiments are still mine, and I shall be happy to be one with you and The Medical Society of New Jersey as long as these goals remain unrealized, and as long as life endures.

*Remarks of Retiring President Buchanan before the House of Delegates, third session, Monday, May 14, 1962.

Golden Merit Awards: 1962

Following are the remarks of President R. M. L. Buchanan, M.D., on the occasion of the Sixth Annual bestowal of the Golden Merit Awards on May 12, 1962, at the Annual Meeting of The Medical Society of New Jersey in Atlantic City.

Some duties are carried out more in a spirit of resignation than of eagerness, but the duty which is now mine, as president of The Medical Society of New Jersey, is one of the most appealing and delightful that I have ever been called upon to perform.

The privilege is mine—in the name of The Medical Society of New Jersey, of the entirety of the medical profession, and in the name of the countless patients whom they have served—to thank this year's recipients of the Golden Merit Award—present and absent—for the gifts of their skills and of themselves which in fifty years of practice they have contributed to the welfare of their fellowmen.

The last fifty years have been golden years indeed, not only for men and women such as these whom we honor today, but for all mankind, in consequence of the unparalleled progress in the science and art not only of preventing, curing and controlling disease, but also of safeguarding health and extending life.

The men and women of medicine who, like our award recipients, practiced medicine during the last half century are those who have brought the advances of science to the people, who have worked the wonders that have, with such profit to all of us, been wrought.

The Medical Society of New Jersey hails with pride the recipients of its sixth annual Golden Merit Award. It commends them for their splendid lives and thanks them for their splendid service. It prays that God will reward them for the good that they have accomplished and will bless them with many more happy, fruitful years.

The satisfactions of life are bound up with the consciousness of worthy works well done. Your satisfactions, my distinguished colleagues, should be many and deep. You have given to us all an example of dedicated action which will serve to inspire us all as long as we live. We shall admire and love you for it through all the years to come.

Recipients of the Golden Merit Award

ATLANTIC COUNTY

Clarence Ladelle Andrews, M.D., Atlantic City

CAMDEN COUNTY

Lee J. Hammett, M.D., Camden
Thomas Michael Kain, Sr., M.D., Miami, Florida
Charles Edward Pike, M.D., Oaklyn
Ernest B. Shaw, M.D., Camden

ESSEX COUNTY

Harry Noah Comando, M.D., East Orange
Charles George Crane, M.D., New Providence
Albert Groves Hulett, M.D., Orange
George Joseph Kempe, M.D., Union
Benno Liegner, M.D., Newark
Eugene Merliss, M.D., Newark
William Timothy Rumage, M.D., Newark
Vera Schectman, M.D., Newark
Thornton Stearns, M.D., Orange

HUDSON COUNTY

Frank Bortone, M.D., Jersey City
Edmund Joseph Daly, M.D., Jersey City
Arthur William Justin, M.D., Weehawken
George Conde Lawsing, M.D., West New York
Edward Emanuel Lupin, M.D., Bayonne
Hugh Henry Tyndall, M.D., Weehawken

MERCER COUNTY

Rolla Grant Barry, M.D., Trenton
Jacob Max Schildkraut, M.D., Trenton

MIDDLESEX COUNTY

Abraham A. Pansy, M.D., South River
Charles Joseph Sullivan, M.D., New Brunswick

MORRIS COUNTY

Laurence Martin Collins, M.D., Convent
Inglis Folger Frost, M.D., Morristown

PASSAIC COUNTY

Frederick Patrick Lee, M.D., East Paterson
Hyman Joseph Udinsky, M.D., Passaic
Albert Van Eerde, M.D., Hawthorne

SOMERSET COUNTY

William John Albrecht, M.D., Somerville
Mason William Henry Pitman, M.D., Bordentown

UNION COUNTY

Charles Fuller Card, M.D., Rahway
Robert Jefferson Childers, M.D., Plainfield

N. J. Town to be Health Pilot

An illness profile is being drawn for Levittown, New Jersey. This is aimed at answering questions such as:

How does acute illness start? How does it progress through a community? Can a mass outbreak of disease be foreseen and can effective measures be devised to arrest its further spread? These are some of the questions that will be asked and, hopefully, answered by the Levittown study.

The program is financed by a United States Pub'ic Health Service grant which will be supplemented by use of staff, laboratories, and funds of the New Jersey State Department of Health.

For efficient program-operation, a fairly homogeneous community was sought so that markedly different neighborhoods would not create variables in the spread of disease. A central sewerage system relatively free of industrial and commercial wastes was also needed. The community had to be distinct enough in its boundaries so that most medical care was administered by a comparatively small group of physicians. And the physicians themselves would have to be enthusiastic enough to be wi'ling to sacrifice the time and effort to provide the necessary information on all patients with acute illness. Levittown, N. J. meets all these requirements.

Dr. Martin Goldfield, project director and Assistant Director of Laboratories for our State Department of Health, has announced that the study will use six major approches:

(1) Physicians will submit daily reports of all new illnesses to the State Department for recording and tabulation.

(2) Specimens will be collected from sick individuals for analysis.

(3) Specimens will be collected from well neighbors of sick persons, who will serve as controls. Follow-up studies may tell why some persons in a neighborhood get sick and others do not.

(4) Sewage from central points will be tested regularly for infectious organisms.

(5) Technicians will study the correlation between the viruses found in human beings and in the sewage.

(6) Efforts will be made to determine whether the presence of disease organisms in the sewage can be used to predict occurrence or spread of disease in the community.

Practicing physicians of Levittown will benefit immediately because the project offers bacteriologic detection services to patients through their doctors. The dramatically rapid fluorescent antibody technic for spotting streptococcal il'ness will be available to physicians. This test eliminates the need for "guess-work" as to whether a fever, sore throat, or respiratory ailment stems from a streptococcus infection. It is an advance beyond conventional slower culture methods because of its speed in identifying streptococci.

This quicker recognition (often by five days) permits earlier application of treatment and can prevent the development of rheumatic fever with its danger of potential heart-damage. The rapid fluorescent test has not often been available to physicians because it involves complex laboratory equipment and procedures.

The project will alert physicians to other specific disease-causing agents which may be prevalent. Three bacterial organisms besides streptococcus can cause acute respiratory illness —pneumococcus, meningococcus, and hemophilus influenzae. A number of drugs are available to combat some of these, but a drug that counteracts one may be powerless against another.

The State Department of Health will organize the daily illness reports of individual physicians and will map them on a community-wide basis. Physicians will receive regular briefings on the specific disease-pattern of the community and the organisms most widely circulating. This information is expected to increase the accuracy of diagnosis and treatment.

The Burlington County Medical Society and all of the township's licensed physicians have endorsed the program.

The study is concerned with the diseases and not with the identity of individuals themselves. As soon as disease-data have been recovered from physicians' records, the association of the disease-data with specific individuals will be destroyed to protect them from even unintentional or accidental publicity.

The Levittown research project will enlarge understanding of how diseases spread, what i'lnesses are caused by many of the newly-recognized viruses, and how frequently they infect man.

After enough data are in, it may be possible to predict the outbreak of a disease in a community, and to develop methods of limiting its spread. This is the long-range hope of the project workers, who are eager to apply their test-tube achievements to the infinitely more complex world of a whole living community.

County Society Reports • • •

Atlantic

A dinner meeting of the *Medical Society of Atlantic County* was held as a combined meeting with the Clyde Fish Memorial Hospital Medical Staff on Thursday evening, March 8, 1962. There was a social hour preceding the dinner. The meeting was called to order by the President, Dr. Josiah McCracken. Minutes of the previous meeting and the Executive Committee meeting were approved as published in the *Bulletin*.

Dr. McCracken congratulated Dr. David B. Allman for his long years of service to the county, state, and national medical organizations as well as for his long service as trustee of The Medical Society of New Jersey.

Dr. Charles Hyman introduced the speaker, Dr. Harold Lyons, Professor of Medicine at the Downstate Medical Center of the State University of New York. Dr. Lyons spoke on pulmonary diseases, particularly emphysema in relation to severe respiratory insufficiency.

Discussion was opened and carried on by Dr. Hyman, who mentioned that we now have young physicians trained in this type of work. A little further discussion was carried on by Dr. Major and Dr. McCracken.

The meeting was adjourned at 9:35 p.m.

LEONARD B. ERBER, M.D.

Reporter

Cumberland

The April 10, 1962 meeting of the *Cumberland County Medical Society* was held Tuesday at 2:30 p.m. at Richard's Farm, "Rainbow Lake," with Dr. Harry A. Reinhart, of Millville presiding.

There were thirty members present.

It was reported that $7,488 will be presented to the Seton Hall College of Medicine by The Medical Society of New Jersey. Physicians have given more than 11½ million dollars to medical schools through the Foundation since it was created. The money was part of the $1,303,161 contributed by the nation's doctors during 1961 to the country's medical schools through the Foundation. Of the total amount, $202,219 was raised through the efforts of the Woman's Auxiliary to the AMA. The total is the largest amount contributed to the Foundation in a single year.

Dr. Mary Bacon, of Bridgeton, reported the progress of the Maternal Welfare Committee by summarizing the latest data on Perinatal Study.

At this meeting the election of officers was held. The new officers are: *President*, Dr. Ralph S. Phillips, Bridgeton; *Vice-President*, Dr. Peter Penico, Millville; *Secretary*, Dr. Frank J. T. Aitken, Bridgeton; *Treasurer*, Dr. Earl C. Lyon, Bridgeton; *Reporter*, Dr. Leonard G. Scott, Bridgeton. Members of Executive Committee for one year: Doctors Jerome Cotler, Bridgeton; Sidney Siegel, Millville; Nicholas E. Marchione, Vineland. Delegates to The Medical Society of New Jersey: Doctors Robert A. Levenson, Vineland, and Sherman Garrison, Bridgeton.

Alternate Delegates: Doctors George Huston, Bridgeton, and Kenneth Corson, Vineland. Member of Nominating Committee of The Medical Society of New Jersey: Dr. Nicholas E. Marchione, Vineland; Alternate, Dr. Sherman Garrison, Bridgeton. County Judicial Committee: Dr. Nicholas E. Marchione, Vineland. Nominees to the Cumberland County Nominating Committee for one year: Doctors Richard Kerdasha, Vineland; Alfred O. Davies, Millville; and Jesse Carll, Bridgeton.

The guest speaker was Gill Pablo, M.D., Thoracic Surgeon of the Woman's Medical and Abington Memorial Hospitals. He spoke on "Surgery for Coronary Artery Disease."

LEONARD G. SCOTT, M.D.

Reporter

Essex

Dr. D. Rees Jensen, of the U. S. Committee of the World Medical Association and a New York City surgeon, reviewed the policies and the activities of the World Medical Association at the monthly meeting of the *Essex County Medical Society* on April 12, 1962 at the Suburban Hotel in East Orange. He illustrated his lecture with two films—one taken during a trip to Russia in 1959 and the other taken during the 1960 meeting of the World Medical Association in Berlin.

The World Medical Association consists of 57 national member groups throughout the free world, comprising 700,000 physicians. It began 15 years ago in an effort to combat political control of medicine and to perpetuate the contacts made during the war. It is a voluntary association entirely without government support. The U. S. Committee is its largest national group, consisting of 7500 members.

The W.M.A. publishes a bi-monthly *World Medical Journal* in English, French, and Spanish; has held two World Conferences on medical education, has reported on the activities of other international organizations and has endeavored to improve the standards and protect the legal and social status of the medical profession.

The American Medical Association has urged every American physician to join the organization.

HARVEY P. EINHORN, M.D.

Reporter

Gloucester

The January 2 meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club—twenty-five members were present.

Dr. Harry Burros, urologist at the Underwood Hospital, spoke on "aortography"; and, to maintain a balanced menu, Dr. Donald Kudrec talked about the Civil War. (Local talent was used because of anticipated difficulty with travel.)

Dr. George Booth, our treasurer, gave a detailed report of receipts and expenditures, and deposits. A gift of $500 was made to furnish a room in our County Home, "Shady Lane."

Doctors A. P. Battaglia, Giacinto Maruca, and Philip E. Ramirez were elected to associate membership, and Dr. Joseph S. Dortch to courtesy membership.

Dr. A. Guy Campo, who recently addressed the Rotary Club on "Medical Care for the Aged," urged physicians to send letters to legislators in reference to the King-Anderson Bill. Dr. Brower commended Dr. Campo (President of the New Jersey Academy of General Practice) for his fine work done to thwart passage of HR 4222.

Our current delegates to State Society convention are: Doctors A. Guy Campo, 3 years; T. F. Flynn, 2 years; C. I. Ulmer, 1 year; and William Beall, 1 year. Alternates are: Doctors D. B. Weems, Sr.; F. M. Brower; S. T. Camp; and D. M. Rogers.

The *Gloucester County Medical Society* met on February 15 at the Woodbury Country Club, with Dr. Rudolph DePersia, President, calling the meeting to order. Sixteen members were present.

Dr. Jack Helwig, associate director of the Cardio-Vascular Research Clinic of the University Hospital, spoke on "Selected Cardio-Vascular Abnormalities."

A communication from Hudson County Medical Society was read relative to the assumption by the State Society of responsibilities resulting from applications for membership in affiliate societies.

The following reports were given: *Judicial Committee*, Dr. Flynn; *Legislative Committee*, Dr. Campo; *Delegate* to AMA, Dr. Patterson.

Discussions on old age assistance followed.

The need for a geriatric clinic was discussed and Dr. J. Kehler recommended publicizing by doctors of their efforts to reduce rates for 65 or over patients.

On the 15th of March, Dr. Rudolph DePersia, President of the *Gloucester County Medical Society*, introduced the speaker, Dr. Daniel J. McCarty, Jr.

Dr. McCarty, Assistant Professor of Medicine and Chief of Rheumatology at Hahnemann Medical College, spoke on the systemic effects of various oral steroids.

Dr. Campo reported on Bill S-12. Gloucester County Medical Society favors S-32.

A symposium on bacterial and parasitic diseases will take place at Cherry Hill Inn on May 23 at 10:00 a.m.

A Contact Committee was appointed.

DOROTHY M. ROGERS, M.D.

Reporter

Passaic

The regular monthly meeting of *The Passaic County Medical Society* was held March 20 1962 at 9:00 p.m. at the St. Joseph Hospital in Paterson. More than 125 members were present. The occasion was the Sixth Meyer Notkin Memorial Lecture, co-sponsored by the Society and the Passaic County Heart Association.

Dr. Levine, President, welcomed those attending. He praised the late Dr. Meyer Notkin, not only for the outstanding work he did for the Heart Association and St. Joseph Hospital, but also for all of the people that he helped: "We who knew him intimately are grateful for the privilege of having known him as a friend and colleague."

The following were elected to membership: Active by transfer—Drs. Marion J. Finkel of Fair Lawn and Harvey D. Karkus of Paterson; Active to Courtesy—Dr. John A. Schultz of Paterson.

A resolution on the death of Dr. Richard P. Battin—submitted by Dr. Carl Rasin—was unanimously adopted.

Dr. Oscar Goldstein, program chairman of the Passaic County Heart Association, addressed the group briefly. Dr. Edward Wolfson, program chairman of the Passaic County Medical Society, introduced the guest speaker of the evening: William Dock, M.D., Professor of Medicine, Downstate Medical Center, Brooklyn New York, State University of New York. Dr. Dock spoke on "Hypertension," followed by a question and answer period.

At the conclusion of the scientific session, a collation was served by the St. Joseph Hospital.

ALEX E. SCHEFRIN, M.D.

Reporter

Salem

At Richman's on April 20 at 4:45 p.m., President William Sprout called to order the regular session of the *Salem County Medical Society*. He announced that, at a symposium on "The Obese Child"—to be held in Lower Penns Neck—the Society will be represented by Dr. Isadore Lipkin, member of a panel composed of a nutritionist and the local school psychologist.

Upon recommendation of the Credentials Committee, Dr. Samuel Reed of Alloway was admitted to full membership.

The annual dinner committee chairman, Dr. Frank Winters, reported that the guest speaker for the event will be Mr. Louis P. Shannon, Public Relations Director at DuPont's Chemical Works; his topic, "Disappearance of the Obvious."

Dr. John Madara reported on pending and proposed measures before the State Council on Legislation: (1) to make it possible for a living person to will his body, or parts thereof, for scientific purposes within 24 hours postmortem; and (2) to give privileged communications to physicians.

The following were elected to office: President, Dr. Wilbur Staub; Vice-President, Dr. Philip Boyer; Secretary, Dr. George F. Reichwein; Treasurer, Dr. Don McLean; and Reporter, Dr. John Dooley. Delegates to the State Society: Drs. C. S. Davison, Harry W. Fullerton, and R. Louis Silverman; Alternates: Drs. John S. Madara, Frank Xhilone, and William R. Staub. Dr. Davison is the Nominating Delegate; Dr. Fullerton, his alternate. All the foregoing are to be installed at the annual dinner meeting on May 20.

After a humorous discussion by our President concerning the old sanitation regulations still present on the books, Dr. Staub introduced the guest speaker, Dr. James Roth, Chief of Gastroenterology at Graduate Hospital in Philadelphia, who spoke on "aerophagia" with its many ramifications. Many illustrative x-rays were shown to highlight case histories. One of the many interesting points was consideration of this syndrome in the differential diagnosis of intestinal obstruction.

After an enlightening discussion, all retired to dinner.

JOHN T. DOOLEY, M.D.
Reporter

Annual Report of the Passaic County Medical Society*

David B. Levine, M.D., President, Paterson

At the President's installation dinner in October 1961, I stated among other things that my purpose as President was to emphasize renewed and continued loyalty of the members to the Society. How well and to what extent I have accomplished my goal can be answered only by others. My report will deal with a factual summary of the Passaic County Medical Society activities during the past year.

Our work was greatly facilitated by the officers who attended regularly the meetings of the Welfare Council and who aided in the formulation of the policies of your society.

The chairmen and members of the committees have been a great help in solving many problems. Some committees have accomplished a great deal and have demonstrated what leadership and interest in the Society can do. Their accomplishments deserve our special mention and our many thanks.

Dr. Edward Wolfson and the program committee have done an outstanding job. The attendance at the monthly meetings has increased modestly, the subjects discussed were of a wide scope and interest. They varied from scientific to economic and community problems. The meetings were devoted to subjects such as "A New Medical School for New Jersey," "Fluoridation—Dental and Medical Aspects," "What Price Prescriptions" and "Hypertension," to mention only a few. We held joint meetings with the Passaic County Heart Association, Passaic County Dental Association, and Passaic County Pharmaceutical Association.

Dr. Wayne Hall and his Postgraduate Education Committee have offered the membership the following courses: (1) A course in psychiatry given by the Society of Clinical Psychiatrists of Northern New Jersey; (2) A course on the newer aspects of pharmacology; (3) Lectures on cardiac surgery, chest trauma, pulmonary tumors and a demonstration of the closed method of cardiac massage and mouth-to-mouth resuscitation.

No fees were charged to the members of the Society for any of these courses.

Through Dr. Hall's efforts, the Passaic County Medical Society was host to police, firemen, first-aid and civil defense personnel as well as physicians and dentists at a session on the "closed chest method of heart massage."

Another outstanding committee was the Judicial Committee with Dr. Leo Thron as its chairman. A tremendous amount of quiet and

*Received after closing date for April issue.

efficient work was done by this committee in solving problems of conduct, of complaints against the profession received by the society, and other items. Dr. Thron utilized one meeting of the Society in December 1961, to acquaint the members with the actual cases as they are taken up by the committee. The meeting was an exceptionally valuable one.

Dr. Peter Berkhout with the Medical Practice Committee has continued to stimulate the Society with his perennial enthusiasm and interest. His committee emphasized a campaign for influenza immunization and for tetanus toxoid immunization. Dr. Berkhout has been an inspiration to all of us, and to keep him from getting lazy we burdened him and his committee with a new project for this year—annual physical examinations for physicians. It is the hope of the Society that this committee, with the help of the Cancer Control Committee, will institute facilities for such examinations at the local hospitals.

The brand new indoctrination committee held an invitation luncheon for our new members. Dr. Herbert Cole presided at a very friendly social gathering of the new members together with the officers of the society and the committee members.

Another new committee appointed this year was the Future Physicians Club, under the chairmanship of Dr. Bernard Sklar. A number of preparatory meetings were held by this committee. Its importance will become more apparent with time.

Dr. Edward Wolfson was instrumental in arranging a May 1962 trip to Paris for members of the Society at a very much reduced fare.

We have amended our constitution to permit resident physicians in nearby hospitals who reside in Passaic County and who are licensed in New Jersey to become associate members. This will make these young residents eligible for malpractice insurance, and will bring them into organized medicine at an earlier time.

Dr. Frederick P. Lee retired as Health Officer of Paterson this year. The Passaic County Medical Society has taken recognition of his thirty-seven years of service to the community by a special resolution. In this connection, we were gratified that the mayor of Paterson appointed a qualified physician to succeed Dr. Lee, namely Dr. J. Allen Yager, a former president of our society. Dr. Yager, among other things, was instrumental in organizing a community health council. At his invitation, your Society is represented on this council by its Public Health Committee.

The building trustees suggested consideration of the sale of our present building after having studied the problem for some time. The idea was *not* approved by the members, who voted against any change at the present time. Dr. Harry Wolfson will now be able to proceed with some of the needed improvements on our present headquarters building. The Society is indebted to Dr. Wolfson and his committee for the conscientious work they have done.

Our Public Relations Committee, with the help of Mr. Randall Norris, our Public Relations counsel, held a dinner for the press, which has become an annual event. The dinner was well attended by our guests, representatives of the three daily newspapers in Passaic County, as well as by the Officers of the Society and members of the committee. We are proud of our relations with the local press and we believe that they are constantly improving.

A total of about 1,600 people attended two forums sponsored jointly by the Passaic County Medical Society and the *Passaic Herald-News*. These forums have become yearly affairs and have been organized with the aid of Mr. Norris and the Society.

Our Bulletin has been published every month throughout the year under the editorial guidance and management of Dr. John Ianacone and Mr. Norris. It has served as an informative and useful periodical for the members.

We have had excellent cooperation with the Woman's Auxiliary under the direction of Mrs. Joseph Rubé, the president. We have subsidized the Homemakers Service for $1,000 again this year. I wish to thank Mrs. Rubé for the enjoyable Doctors' Dance and the invitation to the Luncheon, and especially for assigning Mrs. Levine to be our hostess at the monthly meetings.

The daily chores of our office were ably handled by our Executive Secretary, Mrs. Katherine Cingale, and her assistant, Mrs. Catherine Quinn. I do owe both of these ladies a debt of gratitude for making my term in office more enjoyable and much easier.

Announcements • • •

Study and Vacation Period at Saranac

You are invited to attend the symposium for general practitioners on pulmonary diseases in Saranac Lake, New York, July 9-13, 1962. Fee for this is $75. A deposit of $10 should accompany the application. This deposit is applicable to the total registration fee. It is not refundable if the registrant fails to attend the symposium, but may be applied toward a future symposium registration.

Sessions will be held in Hotel Saranac and sanatoria and laboratories in the Saranac Lake area. Physicians desiring to make patient rounds will have that opportunity.

A pamphlet describing recreational facilities of the area is available if you wish to plan symposium attendance as a family vacation. Many physicians attending previous symposia brought their families to Saranac Lake. So that your families may have use of the car to enjoy the many vacation facilities of the surrounding Adirondack Mountains, transportation will be provided from Saranac Lake to the various meeting places.

A program of scenic tours has also been planned for your family should they wish to join with the other families in visiting the area.

This seminar is acceptable for 27 hours GAP credit. For registration or more details, write to Registrar, P.O. Box 627, Saranac Lake, New York.

Cancer Symposium

On October 22 and 23 there will be a colloquium on the theme of "A Quarter of a Century of Cancer Research: Its Clinical Impact." Sponsored by the American Cancer Society, this seminar will be held at the Biltmore Hotel in New York City. An unusual and practical program has been developed. For details write to Dr. R. N. Grant, American Cancer Society, 521 West 57 Street, New York 19, N. Y.

Dr. Virgilio Alive and Not Kicking

In our May issue we published, among the obituaries, a reference to Dr. Virgilio of Orange. This was an error caused by a mischievous gremlin of unknown ancestry. We are delighted to report that Dr. Anthony Virgilio is very much alive; and in view of his good sportsmanship in reacting to our error, we hope he will remain so a long, long time. If any other member wants to read his own obituary, we are willing to arrange it on request—if the request is notarized. This JOURNAL is printed in Orange where Dr. Virgilio lives, works, and flourishes. We should have checked this better than we did.

Public Health Meeting in Miami

The American Public Health Association's 90th annual meeting is scheduled for Miami Beach October 15 to 19. Registration, exhibits and press headquarters will be in the Hotel Fontainebleau. The opening symposium will bring together leading authorities to discuss the role of health in social and economic development.

Scientific sessions and exhibits will cover a rich spectrum of subjects related to the application of medical research to benefit large numbers of people. Sections will discuss reports from leading practitioners and dental health, engineering, sanitation, epidemiology, food, nutrition, health officers, laboratory, maternal welfare, child health, medical care, mental health, occupational health, public health education, public health nursing, school health, and statistics.

For more details, write to the American Public Health Association at 1790 Broadway, New York City.

Obituaries • • •

DR. LANCELOT ELY

One of the Senior Fellows of our Society, Dr. Lancelot Ely died peacefully on April 15, 1962, at the age of 87. Born in England in 1875, he was brought to New Jersey as a seven-year old boy. At the age of 25 he entered the Baltimore College of Physicians and Surgeons, earning his M.D. in 1904.

He started practice as a country physician in Flanders, in Morris County, an authentic horse-and-buggy doctor of that era. In 1907 he moved to Somerville and was for almost half a century identified with Somerset County. He was a member of Somerville's Boro Council, and was considered the father of the Somerville Boro park system. In 1917 and 1918 he served in the Army Medical Corps and retained a reserve colonel's commission for many decades thereafter. A well-known collector of Indian relics, he had several tours of duty as president of the New Jersey Archeological Society.

He was on the advisory Board of the New Jersey State Museum. In 1934 Dr. Ely became President of The Medical Society of New Jersey. In his private practice, he was a surgeon. In 1950 he retired and moved to Toms River.

DR. HARRY H. HORNSTINE

Scheduled to receive the Golden Merit Award in 1962, Dr. Harry H. Hornstine died on April 14 after a brief illness. Dr. Hornstine was a general practitioner and a past-president of the Cape May County Medical Office. For three decades, he was a Health Officer for Wildwood, and had several tours of duty as Coroner of his County. Dr. Hornstine was active in civic and synagogue affairs in southern New Jersey. He was born in 1889 and was graduated from the medical school of the University of Maryland in 1914.

DR. CHARLES E. TABER

A heart attack on April 19 took the life of Dr. Charles E. Taber at the untimely age of 58. A 1932 graduate of the medical school of the University of Tennessee, Dr. Taber became an anesthesiologist at New Brunswick's St. Peter's Hospital. Originally a family doctor in Middletown, New York, he left general practice in 1939 to do graduate work in anesthesiology, eventually becoming a board diplomate in that specialty. Dr. Taber was active in the affairs of the Middlesex County Medical Society.

AMPAC NEWS

Sen. John G. Tower of Texas, and Rep. Harold B. McSween of Louisiana were among the speakers at the $25-a-plate banquet given by the American Medical Political Action Committee in the Grand Ballroom of Chicago's Palmer House on June 24.

Physicians and their wives, as well as many others interested in political education and action by the medical profession thronged the banquet and participated in other related activities held for the day. Dr. Gundersen said: "The profession is fast awakening to the need for effective, concerted political action. This is evidenced by the snowballing support being given state political action committees and AMPAC itself.

"The Chicago program aroused unusual interest; those who took part in the activities at the Palmer House found their time well spent."

Sen. Tower is the first Republican to be elected to the Senate from Texas since Reconstruction. He is the only Republican Senator ever elected by popular vote from any of the former Confederate states. He is the only Senator to serve on the influential Senate Republican Policy Committee during his first term, and also functions as a member of the Republican Senatorial Campaign Committee.

Sen. Tower fills the seat vacated by Lyndon Johnson, now Vice President. A former professor of political science, Sen. Tower is assigned to two major Senate Committees—Banking and Currency, and Labor and Public Welfare.

Rep. McSween was elected to the 86th and 87th Congresses from the Eighth District of Louisiana. A Democrat, he practiced law prior to entering public life. He is a member of the House Committee on Agriculture.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Clinicial Diagnosis by Laboratory Examination. J. A. Kolmer, M.D. Ed. 3. New York, 1961. Appleton-Century-Crofts. Pp. 576, with illustrations. ($10.00)

Pathology, as Dr. Kolmer says here, is the foundation on which the house of medicine is built. And pathology is not the medicine of the dead house: it is the keystone of the medicine of the living. Since 1943, Kolmer has been one of the standard manuals in laboratory diagnosis. This 1961 edition thoroughly updates it. The text includes 18 diagnostic tables that give a wonderfully compact scheme of differential diagnosis. Included in the book is a chapter on immunologic skin tests, another on parasitologic examinations, and one on mycology. This is in addition to the standard gamut of studies of blood, urine, sputum, feces, spinal fluid, seminal fluid and various exudates and transudates. Also covered is material on biopsy and cytologic examinations, toxicology, vitamin assays, and blood groupings. A simple leafing of the volume will show why it has, for two decades, been a standard in its field.

VICTOR HUBERMAN, M.D.

Mayo Clinic Diet Manual. By the Committee on Dietetics of the Mayo Clinic. Pp. 222. Philadelphia, 1961, Saunders. Ed. 3. ($5.50)

What can or should the patient eat? This is the most frequently asked medical question in the office, home, hospital or clinic. To answer this question, frequently multiple sources must be looked into with loss of time and effort. This Mayo *Manual* adequately answers the problem for the conditions commonly encountered by the general practitioner, pediatrician, internist, and surgeon. The chapter headings, format, general discussion, the food tables, sample menus and index make it simple to extract the desired information in a form readily transcribed to the nurse, assistant and patient. This manual fulfills the function for which it was written. However, it is hoped in future editions, the authors would go one step further and in a similar simplified and concise manner include suggested diets for the more bizarre and rarer metabolic conditions requiring dietary care and management.

MORRIS A. MONALOY, M.D.

The Nature of Sleep. Edited by G. E. Wolstenholme, M.A. and M. O'Connor. B.A. Boston, 1961. Little, Brown. Pp. 416. ($10.00)

In 1960, the Ciba Foundation sponsored a colloquium on sleep. This book is the transcript of that session. As with many of the earlier Ciba Foundation symposia, the emphasis is on basic science rather than clinical usefulness. For instance, the practitioner will not, by reading this book, learn how to treat insomnia. An overview of the topics covered will give the picture: polygraphic and EEG studies of sleep, effect of waking on single unit activity in cats, energy metabolism during sleep, hibernation in animals, sleep patterns among men at the north pole and south pole, and effect of sleep deprivations on performance. This is a solid arbeit for serious students of the subject or for the scholar; and it won't hurt the clinician any to learn something of the experimental and physiologic substrate of the condition in which he spends 25 per cent of his time.

HERBERT BOEHM, M.D.

The Compleat Pediatrician. W. C. Davison, M.D. and J. D. Levinthal, M.D. Duke University Press, 1961, Durham, North Carolina. Section: 257, Ed. 8 (pages not numbered). ($4.50)

In 1919, a group of young pediatricians at Johns Hopkins assembled a note book of easily forgotten facts and procedures. Out of this developed what has become the most unusual and most useful pediatric text in English. It has been reprinted, revised and updated continually since 1919. Sixty thousand doctors have bought it in one or more editions. Under the circumstances, a critical review would seem to be superfluous: it has already been judged and found valuable.

It is an almanac of pediatrics, with everything squeezed in, arranged ingeniously with key numbers for ready reference. It takes a few minutes to get the hang of it, but once you do, you find this an extraordinarily handy volume, a veritable one-book library. You can start with a symptom and find lists of the conditions that cause it; or you can start with a body system (say, the respiratory) and read all about it. The book contains meaty and practical advice about treatment. It includes tips on examining children, developing

special diets, what to put in the pediatrician's bag, how to calculate drug dosage and how to handle emergencies. The book has a sensible, flexible binding. It is modest enough in price to permit the practitioner to own two—one for the bag, one for the desk. The British Medical Journal called the seventh edition a "Bradshaw" which, for those who know the British is praise indeed. And according to a Belgian journal, *ce volume est le breviare en matiere de pediatrie*, to which this reviewer can say, *ja*, *oui* and *da*.

RALPH N. SHAPIRO, M.D.

Appraisal of Current Concepts in Anesthesiology. Edited by John Adriani, M.D. St. Louis, 1961, Mosby. Pp. 279 ($7.75)

"How best to scan the ever-increasing multitude of scientific periodicals and digest those that were pertinent in a manner meaningful to trainees," is a problem that faces all of us, not only Dr. Adriani's residents. He has attempted to solve this by "assigning staff members and trainees to review topics of timely interest which appear in current journals, including a brief statement on early thinking on the subject and adding a summary of current concepts." Believing that certain of these reviews would be of interest to others, he has edited and assembled them in this book.

The result is highly successful. Well recorded, well documented, the papers offer a view of fundamental anesthesiology. Their range is wide. Read a paper, a subject at a time. They are thought-provoking. I highly recommend "Current Concepts," not necessarily as a short-cut to replace a study of current literature but rather more importantly as a stimulus to further study.

HERMAN I. ROSEMAN, M.D.

Aids to Physiology. E. T. Waters, D.Sc. London, England, 1961. Balliere, Tindall and Cox. Available in U.S.A. through Williams and Wilkins, Baltimore. Pp. 283. Fifth Edition. ($3.00)

In remarkably compact form, this pocket-size, hard-bound book covers the highlights of human physiology. Though aimed at medical students, it provides an excellent and authentic refresher for the practitioner, and its modest cost makes it available to any medical scientist. The parsimonious use of diagrams and sketches is regrettable, but extensive inclusion of photographs would have added to the bulk and cost. In terms of its utility and accuracy this is a superior text. It cannot replace the more familiar king-sized tomes; but as a supplement or a ready review, the reader will get more than his money's worth.

ULYSSES M. FRANK, M.D.

Traitor Within: Our Suicide Problem. E. R Ellis and G. N. Allen. Garden City 1961, Doubleday. Pp. 237. ($3.95)

Among middle-aged men, suicide is the fourth commonest cause of death. While physicians may know a lot about suturing cut throats or suggesting antidotes for poison, we haven't given much thought to the prevention of suicide. In fact, we doctors are not especially skilled at recognizing a potential suicide. In the appendix to this book, there is listed a set of clues to suicide, as compact and practical a guide as I have ever seen. We practitioners ought to know more about these things.

In this country there are at least 150,000 serious suicide attempts a year. Yet there is little systematic effort to study the problem or control its manifestations. There are organizations for research and control of poliomyelitis, leukemia, nephrosis, tuberculosis, and muscular dystrophy—none of which cause anything like the number of suicide deaths.

The authors of this book are neither psychiatrists nor sociologists. They are journalists. They make their impact by dramatic oversimplification, by the naming of names, by an occasional excursion into brutal realism and by catchy chapter titles. Perhaps this is necessary to put some life into a story that otherwise becomes dreary with statistics.

Any physician will find it worth his while to read this inexpensive little book. It will give him material for talks to lay groups; it will give practical pointers about recognizing potential suicides in his own practice; and it will give him food for thought.

ABRAHAM LEFF, M.D.

The House of Healing. By Mary Risley. Garden City, New York, 1961. Doubleday. Pp. 288. ($4.50)

While we doctors like to think of hospitals as our workshops, the truth is that they belong to the total community, and by now, have become community health centers. Their story has never been fully told, but Mrs. Risley makes an awfully good start at telling it. She traces the development of the modern medical center from Babylon and Egypt, through Rome and Arabia, through the hospitals of monks and crusaders, down to our institutions today. Indeed, her final chapter is called "Tomorrow." There is a good chapter on the educational role of the hospital and another on the nursing profession. This text is written with care and affection by a talented woman who is obviously deeply moved by the humanitarian aspects of hospital care. Mrs. Risley has avoided the temptation to be theatrical or to overglamorize her people or her subject. The book is unique in its field and will be the standard brief work on hospital history for a long time to come.

HENRY A. DAVIDSON, M.D.

Meet Dorothy Torppey



The new president of the Woman's Auxiliary to The Medical Society of New Jersey was born Dorothy Mary Corrigan, on May 3, 1912. A native of Newark, she is a graduate of the Benedictine Academy, the Jersey City Medical Center School of Nursing and New York University.

In 1939 she married John Joseph Torppey, M.D., a graduate of Georgetown University. This romance has an unusual history. John was delivered by Dorothy's father, Dr. George F. Corrigan, who was the Torppey's family physician.

During the early years of her marriage Dorothy received a Fellowship and worked as a Public Health Nurse with the Henry Street Visiting Nurse Service in New York City. She then attended the Graduate School of Education at New York University and received her Masters Degree in 1949.

Two years were spent at St. James Hospital where a new course in Public Health Nursing was established and accredited with the New Jersey League of Nursing Education.

After World War II when her husband returned to practice, Dorothy assisted John in his laboratory work. To learn this field she was graduated from an intensive course in medical technology in New York City.

Auxiliary activity has been part of her life since 1939. On the county level she held chairmanships of: Program, Newsletter, Public Relations, Nurse Scholarship, and nearly all the offices in the Essex County Auxiliary. She served as president of the Woman's Auxiliary to the Essex County Medical Society in 1951 and '52. Since then Dorothy has served continuously with the Woman's Auxiliary to The Medical Society of New Jersey.

Her community interests have been several: immediate past-president of Chr-Ill Guild, serving three years in this capacity; a Board member of St. James Hospital Auxiliary, a charter member of Seton Hall Medical Guild, and memberships in the Greystone Park Association and the A'Kempis.

The Torppey's have three teenagers: Kevin age 19, Karen 16, and Brian 15 years of age.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

JUNE, 1962 • VOL. XXXV, NO. 6

TUBERCULOSIS MORBIDITY IN A CONTROLLED TRIAL OF THE PROPHYLACTIC USE OF ISONIAZID AMONG HOUSEHOLD CONTACTS

Results of a controlled study among close contacts of newly-reported tuberculosis cases suggest that isoniazid prophylaxis may be a valuable addition to a tuberculosis contact program.

Isoniazid has four requisites of the ideal prophylactic agent for tuberculosis: it is extremely effective in treatment, safe, cheap, and easy to take. Therefore, the Tuberculosis Program of the Public Health Service has undertaken a series of controlled trials of the prophylactic usefulness of isoniazid in different situations.

One of these trials was among household associates of new cases of tuberculosis who were enrolled in the study at the time the index case was reported to the health department. The present report is limited to tuberculosis morbidity observed in this trial.

PLAN OF STUDY

Contacts of 5,677 persons with newly-reported tuberculosis entered the trial. They were located in 39 communities across the southern part of continental United States and in Puerto Rico. After excluding 479 cases of active tuberculosis found on original examination of the contacts, 25,033 were entered in the prophylaxis trial. Of these, 12,594 were assigned placebo and 12,439, isoniazid. The plan of the study was such that only the central office (PHS) knew the code by which bottles of placebo or isoniazid were assigned. All contacts within one household were assigned the same medication, that is, all had isoniazid or all had placebos. Each contact was asked to take the prescribed number of pills for one year. Daily dosage was on the basis of 5 milligrams per kilogram of body weight, or, for adults, approximately 300 mg.

During the medication year, 24 person on placebo and 34 on isoniazid (excluding five known not to have taken the pills) died of nontuberculous causes.

Boards of clinical investigators reviewed the clinical, bacteriologic, and roentgenographic evidence on all cases of tuberculosis without knowledge of the prophylactic medication the subjects had received.

ACTIVITY STATUS

Roentgenographic evidence of active primary tuberculosis was detected during the medication year in 29 persons receiving placebo and 22 receiving isoniazid. Among those uninfected at the start of the trial, 16 cases occurred in the placebo group and 5 in the isoniazid group. Twelve of the placebo cases and 3 of the isoniazid involved only enlargement of the lymph nodes, while 4 placebo cases and 2 isoniazid showed both parenchymal lesions and enlargement of lymph nodes.

Isoniazid had no effect on the number of cases of primary tuberculosis detected during the year among those infected (tuberculin posi-

Shirley H. Ferebee and Frank W. Mount, M.D., *The American Review of Respiratory Diseases*, April, 1962.

tive) at the start of the trial, with 13 cases in the placebo group and 17 in the isoniazid group. It is generally agreed that the perifocal reaction discernible on roentgenograms appears at approximately the same time as skin sensitivity to tuberculin. This suggests that cases among the initially infected detected after the start of trial may represent primary disease actually present on entry.

Only 12 cases of primary disease have been observed since the participants completed their year of medication, 6 in the placebo group and 6 in the isoniazid.

During the year, extrapulmonary tuberculosis developed in 20 contacts, 16 of these had been assigned placebo and 4 isoniazid.

Pulmonary tuberculosis developed during the year in 62 persons assigned placebo compared with 14 persons assigned isoniazid. The difference is highly significant statistically.

The review board classified each case by the stage of disease at the time the case was discovered by the health department. Nearly one-fourth had minimal disease; one-half had moderately advanced disease; the others, far advanced disease.

RISK FACTORS

The risk of tuberculosis, chiefly primary disease, was high for children less than 5 years of age, but very low for children from 5 to 9 years. Ten to 14 years appeared to be a period of transition from low risk to the high rate of pulmonary disease in young adults. After age 15, the risk remained high until age 30, when it declined slightly, with a considerable reduction after 45 years of age.

The size of the initial tuberculin reaction was directly related to the risk of disease. The risk was lowest for contacts with reactions of less than 5 mm. of induration to 5 TU of PPD-S and increased with the size of reaction to a rate of 20 per 1,000 for those with the largest reactions.

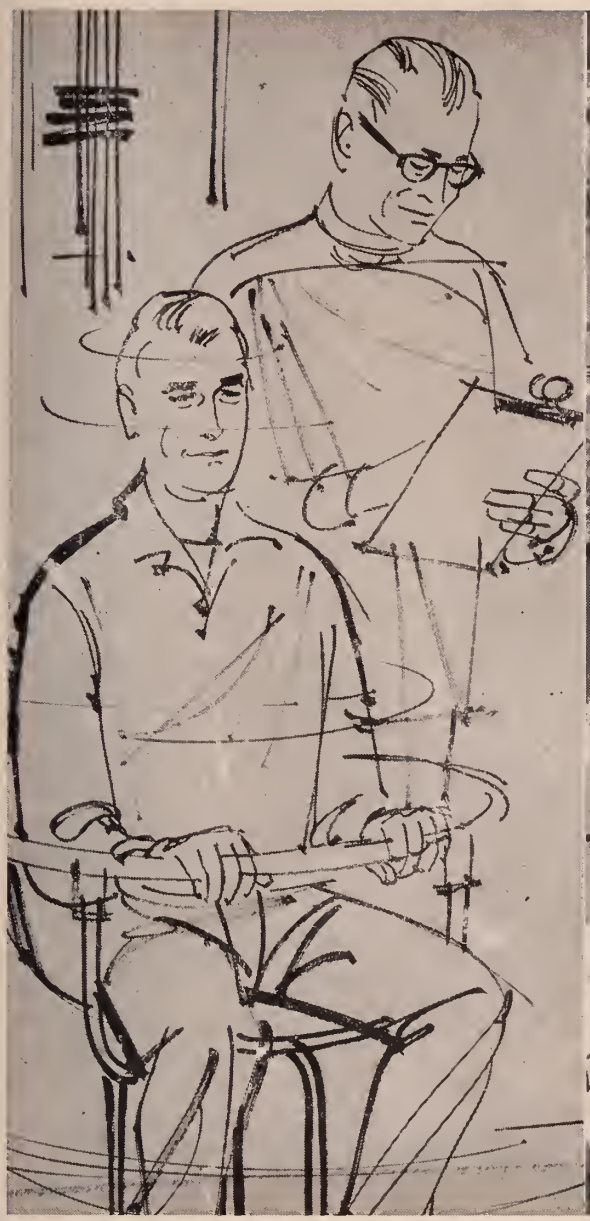
Adult contacts in the placebo group who subsequently developed active tuberculosis weighed less than the average at the time they entered the trial. The initial weights of children who developed tuberculosis did not differ from the average.

Whether a course of isoniazid will eradicate an old infection so that it will never activate may be learned from continued observation of the participants. At present, the data will not support the hypothesis that isoniazid can permanently affect a dormant tuberculous focus. On the other hand, it would seem possible that isoniazid could permanently alter the course of a new infection by eradicating the tuberculous focus and its seedings, thus making subsequent endogenous reactivation impossible. The prevention of primary disease among the initially uninfected and the prevention of extrapulmonary disease give encouragement to this point of view. If this possibility should prove correct, prophylactic isoniazid could be particularly useful in populations in which much new infection is occurring. However, all populations with high rates of tuberculin reactors cannot automatically be assumed to have much recent infection.

At least two-thirds of the contacts in this trial apparently took their pills with a high degree of regularity. From a strictly practical point of view, enough contacts took enough pills to cause a considerable reduction in tuberculosis. This response must be credited largely to the interest taken in these families by the cooperating health departments and probably also to the awareness of danger on the part of the immediate family.

Efficiently organized, the cost of adding isoniazid prophylaxis to an established contact program should be very little. Furthermore, an active procedure to prevent tuberculosis added to the usual passive policy of watchful waiting should improve considerably the cooperation of contact families.

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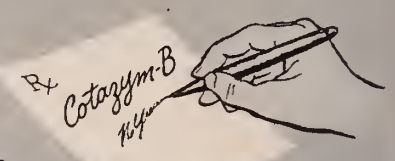
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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Kelfer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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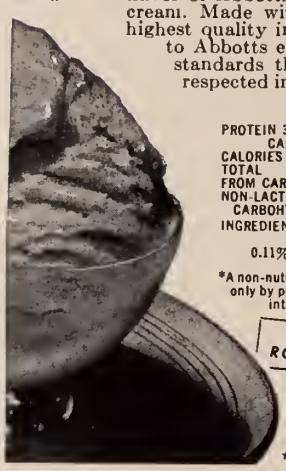
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REFERENCES: (1) Roseman, E.: Neurology **11**:912, 1961. (2) Bray, P. F.: *Pediatrics* **23**:151, 1959. (3) Chao, D. H.; Druckman, R., & Kellaway, P.: *Convulsive Disorders of Children. Philadelphia, W. B. Saunders Company, 1958, p. 120.* (4) Crawley, J. W.: *M. Clin. North America* **12**:317, 1958. (5) Livingston, S.: *The Diagnosis and Treatment of Convulsive Disorders in Children. Springfield, Ill., Charles C. Thomas, 1954, p. 190.* (6) Ibid.: *Postgrad. Med.* **20**:584, 1956. (7) Merritt, H. H.: *Brit. M. J.* **1**:666, 1958. (8) Carter, C. H.: *Arch. Neurol. & Psychiat.* **79**:136, 1958. (9) Thomas, M. H., in Green, J. R., & Steelman, H. F.: *Epileptic Seizures, Baltimore, The Williams & Wilkins Company, 1956, pp. 37-48.* (10) Goodman, L. S., & Gilman, A.: *The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 187.*

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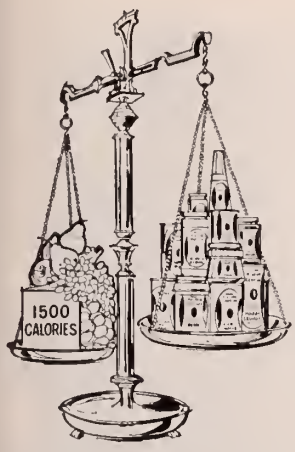
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Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



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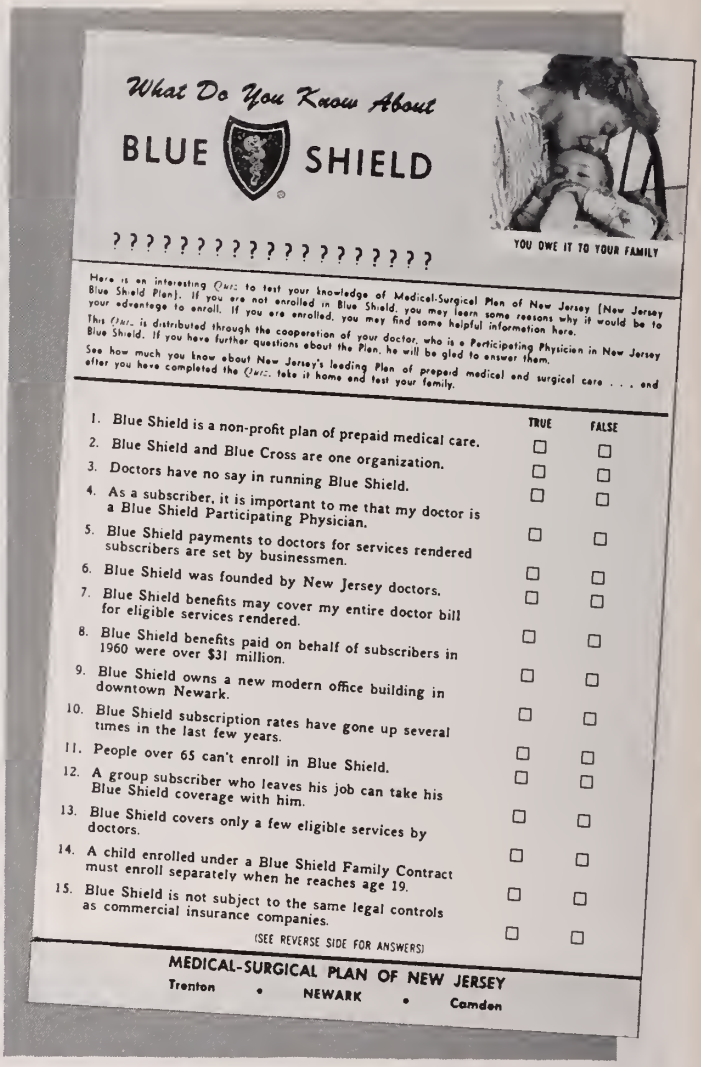
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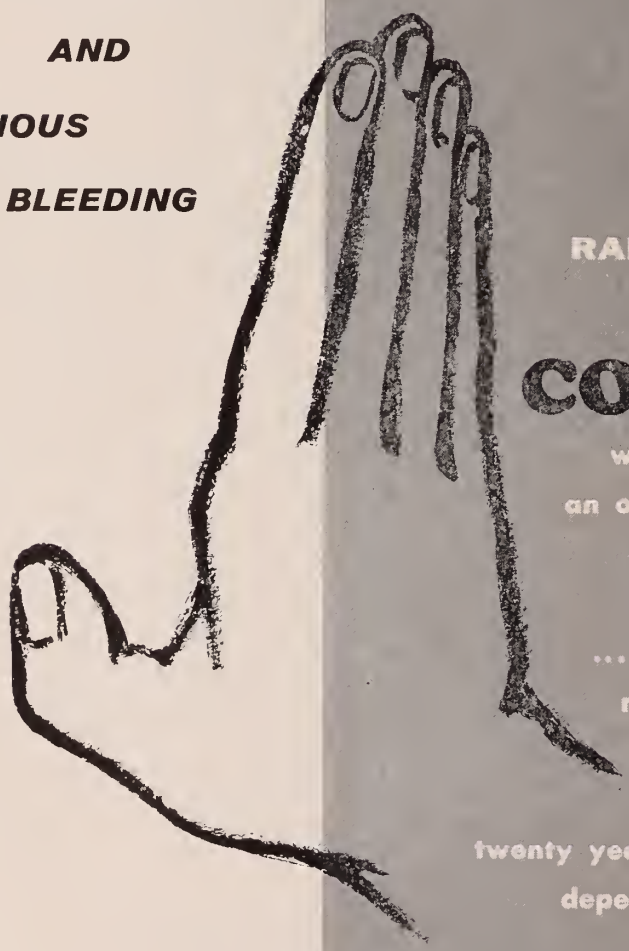
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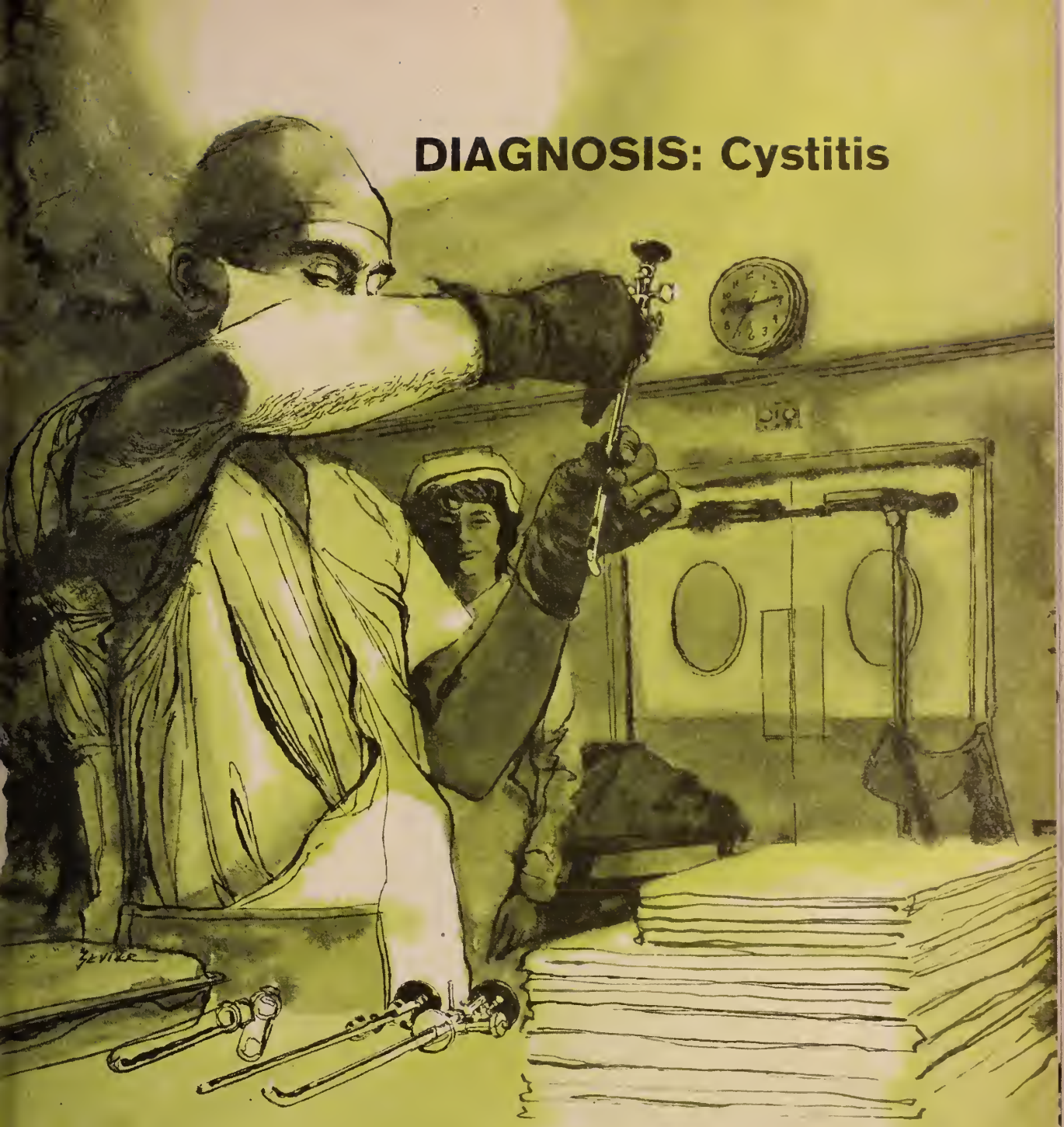
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3. Lubowe, I. I.: Western Med. 1:45, 1960.
4. Weissberg, G.: Clin. Med. 7:1161, 1960.



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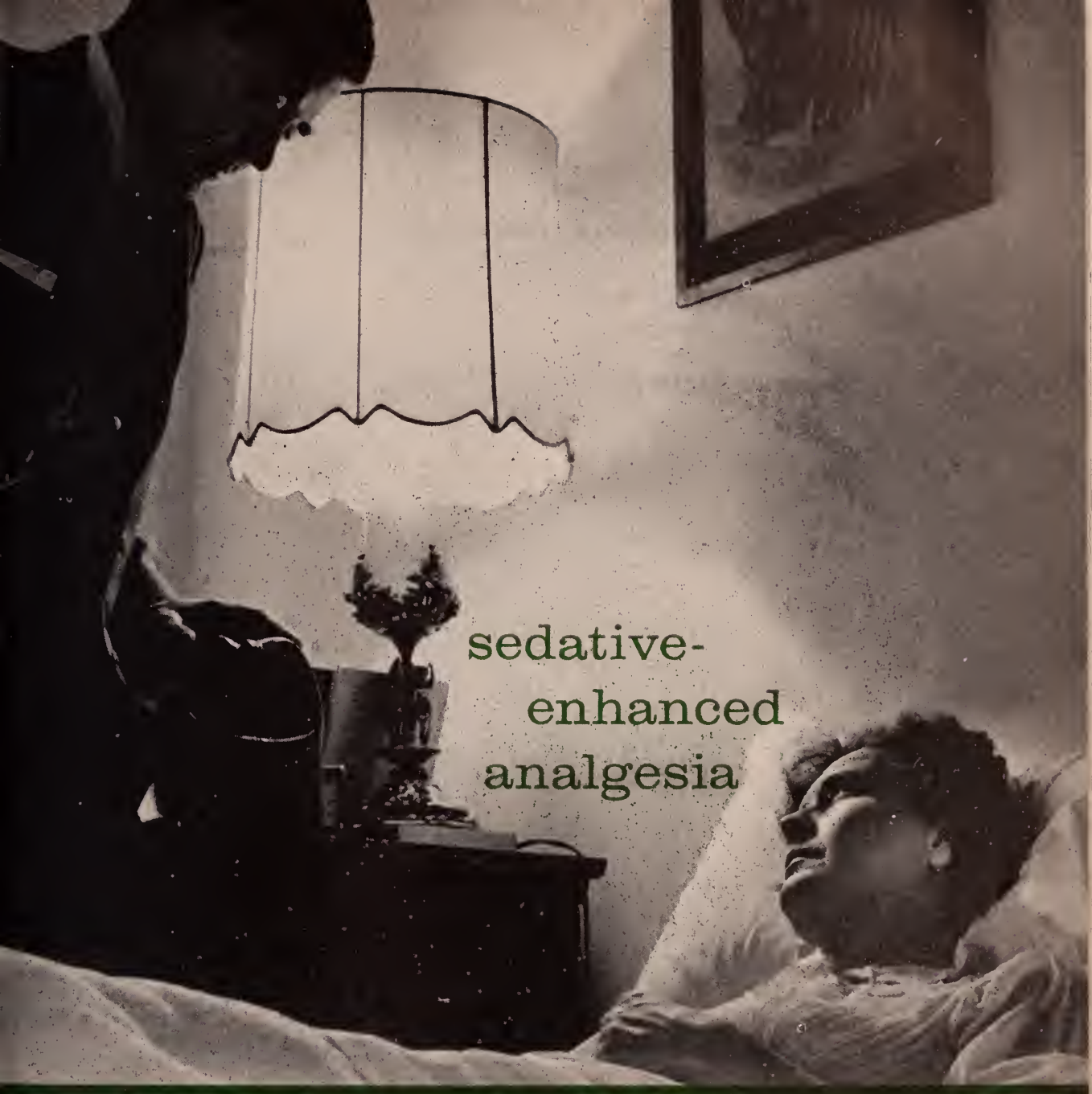
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1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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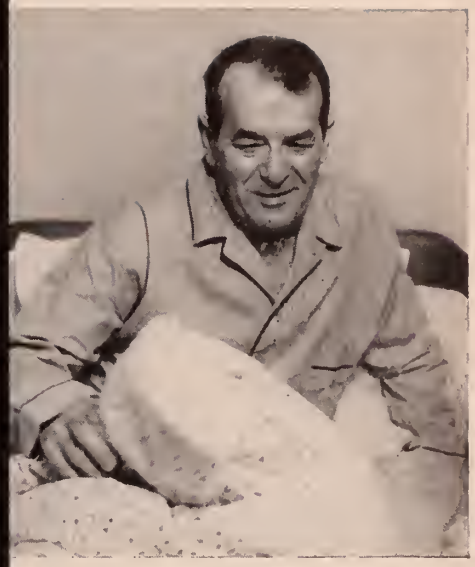


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References: 1. Carpenter, E. B.: South. M. J. 51:627, 1958. 2. Hudgins, A. P.: Clin. Med. 8:243, 1961. 3. Lamphier, T. A.: J. Abdomin. Surg. 3:55, 1961. 4. Levine, I. M.: Med. Clin. N. America 45:1017, 1961. 5. Meyers, G. B., and Urbach, J. R.: Penna. M. J. 64:876, 1961. 6. Perchuk, E., Weinreb, M., and Aksu, A.: Angiology 12:102, 1961. 7. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 8. Schaubel, H. J.: Orthopedics 1:274, 1959. 9. Steigmann, F.: Am. J. Nursing 61:49, 1961.

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references: 1. Prueter, G. W.: Applied Therapeutics 3:351, 1961. 2. Taylor, F. A.: West J. Surg., Obstet. & Gynec. 64:280, 1956. 3. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959. 4. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957.

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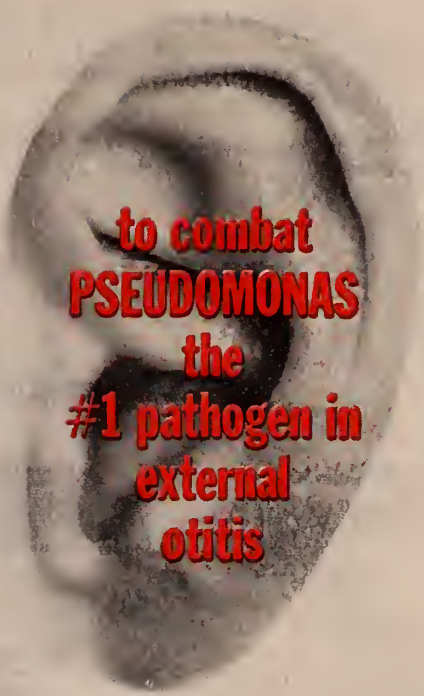
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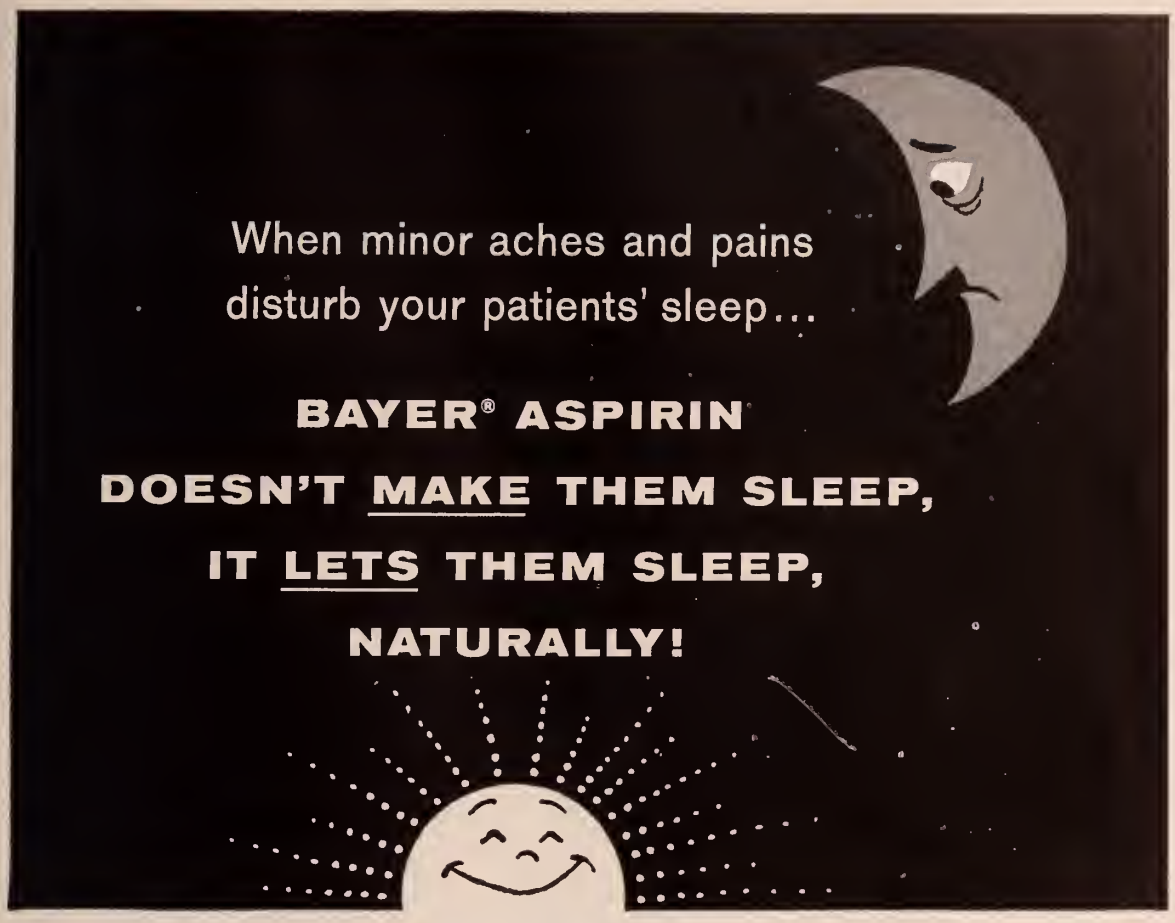
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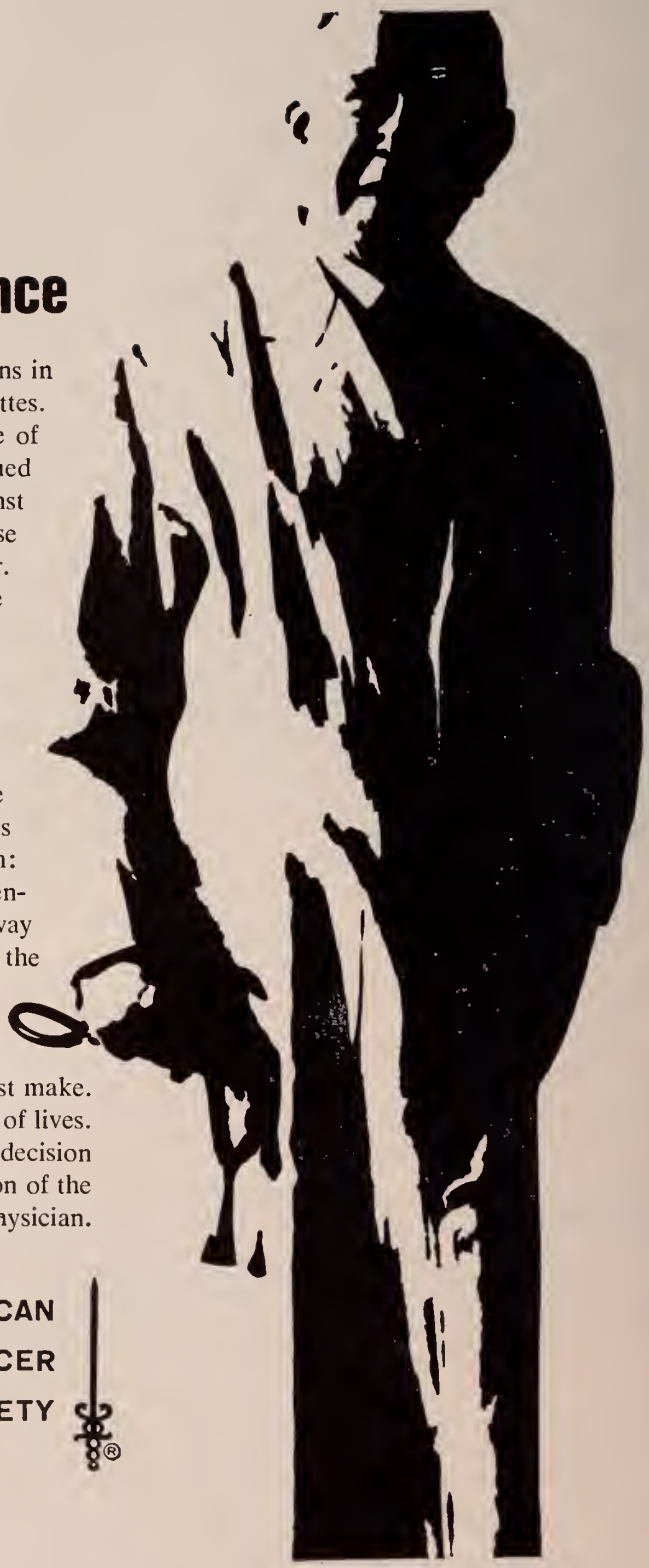


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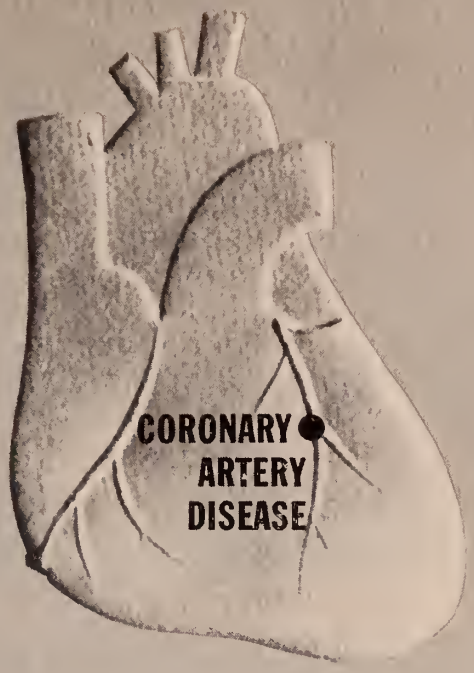
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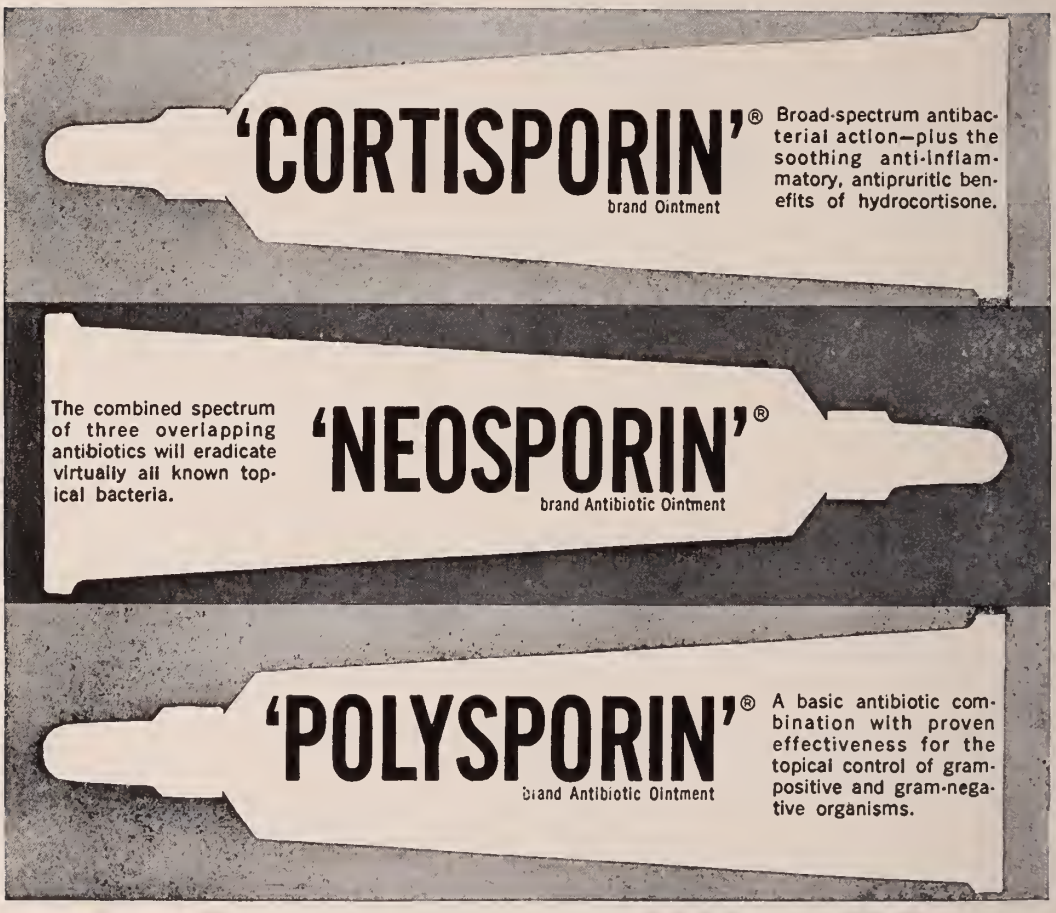
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—Gray, H. R., Wolf, R. L., and Doneff, R. H.: Evaluation of Flurandrenolone, a New Topical Corticosteroid, Arch. Dermat., *84:*18, 1961.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Footnote to the Age of Space

The old writers of science fiction pictured the world of the future as a place of prosperity, technologic advance and general happiness. Hence the derived meaning of the very word "Utopia." Current writers, however, see tomorrow's world as a putrid place—or at best, as a dreary one. (Think of Huxley's *Brave New World,* of Orwell's *Nineteen Eighty-Four,* or of that world to end all worlds, Neville Shute's *On the Beach.*) Some of the signs of things to come are the proposals that women and children learn to handle automatic revolvers to keep neighbors out of their bomb shelters. These gloomy reflections came to us the other day when we received from Allied Chemical the following news release which we here publish in its entirety.

A casket that will not rot, rust, corrode or deteriorate is now being produced by Eternal Products of Long Beach, Calif. The Epic casket, made completely of styrene and rigid urethane foam, is void of wood and metal, and provides an enduring casket, light in weight and low in cost. The new casket achieves strength and fine appearance. It will cremate with less residue than wood. These caskets with high gloss finishes are convertible to twelve variations from hinge panel, couch or full panel sealed or unsealed.

According to Clarence H. McKinley, President of Eternal Products, the Epic casket was engineered, researched and developed over a period of two years to produce a completely new concept in caskets made with space age materials.

We are particularly intrigued by this triumph of conspicuous consumption. This handsome, and eternally enduring casket will disappear completely when cremated, thus achieving something or other.

If the bomb comes, let us hope it will be delayed long enough to permit us to house ourselves in this casket which will "not rot, rust, corrode or deteriorate." It should give the archeologists of 10,000 A.D. something to ponder over!

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Medicine Chest of the Nation*

New Jersey is probably the foremost drug-producing state in the country, with several major medical research and manufacturing firms concentrated in Middlesex, Morris, Union and Essex counties. Many of the most important pharmaceutical developments of the last two decades have resulted from basic research within that small geographic area.

Scientists at four of these firms, for instance, working independently, produced many of the tranquilizers and anti-depressants in medical use. Wallace Laboratories introduced meprobamate, a drug whose trade name, *Miltown,* is a household word. From Warner-Chilcott have come two compounds used in this general field: *Nardil,* an anti-depressant, and *Pacatal* for treatment of psychotic states.

Sandoz recently developed another tranquilizer, *Meilaril.* Roche produced *Librium,* a versatile therapeutic agent for anxiety, tension, and other emotional problems. Roche scientific research also resulted in *Marplan,* an anti-depressant.

Hoffmann-La Roche pioneered the development of synthetic vitamin A and the large scale manufacture of other vitamins.

Ciba made one of the most valuable contributions to modern medicine by isolating reserpine from the rauwolfia native to India.

The hypotensive effect of rauwolfia was discovered in 1940. Ciba research resulted in the isolation of the alkaloid. This alkaloid *(Serpasil)* is among the most useful drugs now available.

Newer drugs which have proved useful in relieving hypertension are Wallace's *Capla* and Ciba's *Ismelin.* They and *Serpasil* represent three distinct entities, each the product of original research.

The discovery of the formula of testosterone by early Organon investigators paved the way for the synthesis by others of this hormone, and this led to interest in anabolic steroids. Organon research includes *Durabolins Bifacton,* which contains the "intrinsic factor" whose absence in pernicious anemia victims prohibits them from absorbing necessary vitamin B.

Some of the most important vitamins in human nutrition were discovered or refined at Merck's Rahway laboratories. Merck Sharp & Dohme research made available the first life-saving sulfonamides. Roche has pioneered in sulfa therapy with *Madribon* and *Gantrisin.*

Merck chemists at Rahway were largely responsible for the early introduction of cortisone. Continuing Merck research in this corticosteroid field has produced *Decadron,* the most powerful analogue of cortisone.

Merck played an important role by supporting Waksman's work on streptomycin, and together with Squibb, made significant contributions to penicillin.

Schering is an important contributor to corticosteroid research. The firm's development of prednisone (*Meticorten*) has provided dramatic relief to sufferers of asthma and hay fever. Schering was among the first to make available in the United States griseofulvin, the first effective antibiotic for athlete's foot. Squibb has done immense research on fungal antibiotics, leading to *Mycostatin.*

Merck spent sixteen years in intensive research before discovering *Diuril,* a most effective oral diuretic. The research work with *Diuril* revolutionized fundamental knowledge of kidney physiology. A newer and more potent derivative of *Diuril,* with ten times its potency, has been introduced by Merck as *Hydrodiuril* and Ciba as *Esidrix.*

Eight per cent of the nation's population suffers from migraine and Sandoz research provided ergotamine, now marketed in several forms by Sandoz and Organon.

*Some of the data in this editorial have been drawn from the October 1961 issue of *New Jersey Business,* a magazine service of the New Jersey Manufacturers' Association.

Another unique product of New Jersey pharmaceutical research is Wallace's *Soma*, used to treat musculoskeletal disorders.

Our State, indeed, is the Nation's Medicine Chest. No less than 18 members of the Pharmaceutical Manufacturers' Association have their plants in New Jersey. These companies employ hundreds of chemists, inspectors, microbiologists, pharmacologists, physicists, samplers, statisticians and technicians in quality control laboratories.

In all, there are 1300 drug firms in the United States. Our State is home of 125 of them. New Jersey accounts for one-sixth of the nation's drug production, an output that added more than $500 million to the state's gross production in 1958. In that same year 15,000 people (many of them physicians and research scientists) were employed by the drug industry here at a payroll topping $90 million.

The list of fine pharmaceutical manufacturers for whom New Jersey is home base would include Carnrick, Chatham, Ciba, Glenwood, Knoll, Maltbie, Merck, Organon, Ortho, Panray, Premo, Reed & Carnrick, Roche, Sandoz, Schering, Martin H. Smith, Squibb, Standard Laboratories, White Laboratories, Wallace, and Warner-Chilcott. There are others for whose ommision we must apologize; but we don't have space to list all 125 names.

We in New Jersey are proud of our companies, proud of their contributions to medical care, and proud of the scientists anonymous who spark-plug the whole vast operation. These scientists provide the initiative, the scholarly background, the technical know-how, and the assurance that the products bearing their companies' names are respected throughout the world.

Decorum and Dignity in the Hospital

The headlong flight into informality and togetherness which characterizes our age has brought with it a consequent tarnish to that patina of quality, good manners. Deplorable when encountered in streets and shops, this slippage is particularly regrettable when displayed about our hospitals.

Time is not so far distant when the attending staff set a high tone of dignity to our institutions, one that rubbed off successively on everyone. One need not go back to Osler, Pepper, or Peabody to find that pleasing virtue—it lies beneath the surface of us all.

Should our hurried and harried lives rob the seriousness of our work of its aura of quality? We think not, but some lifting by the bootstraps is in order. On your next hospital visit, make some comparisons.

Is the nurses' station a business-like place or has it deteriorated into a gossip center, a first-name based smoking room, a home away from home? This station is often a point of contact with patients' relatives and friends, and an impression made here is lasting.

The patient in room 10 is not "that gallbladder"—his name is Mr. Antrobus, and criticism of his food tray or his nursing care is not to be made in his presence or in the presence of others. A decent respect for the feelings of others is basic. Curtain lectures are given behind drawn curtains.

Are we so weary that we must sit on the patient's bed?

Irritability, like a lady's slip, should never show. It is a fault in self-discipline, easily corrected. The place for the latest story is in the cloakroom. Good manners will have a rebirth when we regard everyone involved in the patient's care and comfort as a respected and trusted colleague but *not* as a bosom pal.

The practice of medicine is a serious calling. We must not permit it to be vulgarized.

—From the March 1962 New York State Journal of Medicine.

Announcements • • •

New Diplomates in Obstetrics and Gynecology

The American Board of Obstetrics and Gynecology announces the certification of the following New Jersey residents:

Ronald H. Allen, 20 Wood Road, Tenafly, New Jersey
John W. Arbogast, Jr., 665 High Street, Burlington, New Jersey
Joseph A. deBlois, 858 Berkeley Avenue, Trenton 8, New Jersey
Kenneth E. Dollinger, 19 Lyons Avenue, Newark 12, New Jersey
Robert E. Farabaugh, 641 Franklin Avenue, Nutley 10, New Jersey
John D. Franzoni, 938 Brunswick Avenue, Trenton 8, New Jersey
Robert M. Oshrin, 55 West Blackwell Street, Dover, New Jersey
Arthur Perell, 48 Maple Street, Summit, New Jersey
Norman Reiss, 25 Manor Drive, Newark, New Jersey
Robert A. Rodgers, Jr., 204 High Street, Mt. Holly, New Jersey
Michael G. Salz, 372 Fairview Avenue, Westwood, New Jersey
Jay B. Skelton, 333 Park Street, Upper Montclair, New Jersey
John J. Sprowls, 1067 West Lake Avenue, Rahway, New Jersey
Merrill A. Swiney, III, 35 Bentley Avenue, Jersey City 4, New Jersey
Gabriel Tatarian, 1 Merion Lane, Levittown, New Jersey
Ralph Witmer, Jr., 129 Summit Avenue, Summit, New Jersey

Neurological Positions Available

A full-time position is open for a neurologist on a 220-bed service in a 1,000-bed hospital. Salary is excellent, and there are numerous fringe benefits. Also available in the same hospital are approved residencies in neurology.

For further information on either of these openings, write to the Chief of Staff, Veterans Administration Hospital, East Orange, New Jersey.

Course in Occupational Medicine

Occupational Medicine, a full-time course for physicians, will be given for eight weeks from September 17 through November 9, 1962 by the New York University Graduate Medical School. The seminars will cover preventive medicine, epidemiology, biostatistics, administrative medicine, occupational diseases, and industrial hygiene. Didactic instruction will be supplemented with trips to industrial plants, governmental agencies and union health centers. Opportunity will be given to attend medical, surgical, and clinical-pathologic conferences held in the New York University Medical Center. Tuition is $375.

For further information write to the Associate Dean, Graduate Medical School, 550 First Avenue, New York 16, N. Y.

Surgeon to Meet in New Jersey

The American College of Surgeons will hold its Clinical Congress October 15 through 19 this year in Atlantic City. For the complete program, write to the American College of Surgeons at 40 East Erie Street, Chicago 11, Illinois.

Diabetes Mellitus Check-List

The following information is supplied for your information, at the request of the American Diabetes Association, Inc., 1 East 45th St., New York 17, New York.

Because of its prevalence and chronicity, diabetes mellitus should be the continuing concern of all physicians, regardless of their type of practice. An essential part of treating the condition is teaching the patient how to live with it.

As in any educational program, a systematic approach should be used. Each physician should have certain specific objectives clearly in mind as he teaches his diabetic patients.

To aid him, the American Diabetes Association has prepared the following check list

of nine basic elements of treatment, which constitutes a *minimum* program for diabetes management:

1. Diet
2. Urine testing
3. Action of insulin and other hypoglycemic agents
4. Technic of insulin injection and sites for it
5. Care of syringe and of insulin
6. Symptoms of hypoglycemia
7. Symptoms of uncontrolled diabetes
8. Care of the feet
9. What to do in case of acute complications

This guide is not only of value in the initial education of a new diabetic, but can also be most helpful to both patient and physician in the subsequent years of management.

Subcommittee on Teaching of Diabetes in Hospitals of the Committee on Professional Education is as follows:

George J. Hamvi, M.D., Chairman, Columbus, Ohio; Thomas H. McGavack, M.D., Vice Chairman, Martinsburg, West Virginia; Lewis B. Flinn, M.D., Wilmington, Delaware; Edwin W. Gates, M.D., Niagara Falls, New York; Robert C. Hardin, M.D., Iowa City, Iowa; Edgar A. Haunz, M.D., Grand Forks, North Dakota.

Legalization of Narcotics?

In a recent release of the University of Illinois, Professor Max S. Sadove, head of the anesthesiology department there, is quoted as saying that "legalization of narcotics to the point where certain drugs can be intelligently administered through proper channels is both realistic and necessary."

Our present system, he suggested, means that instead of alleviating the addicts' need or directing it along normal channels, we force them to turn to pushers, and thus compound the problem.

Punishment of dope peddlers by "severe and enforced laws" is not enough in itself, he added.

"We need also," he stated, "to take a good look at the British system of handling this problem . . . and then attempt to modify it to suit our own situation." In Great Britain an addict can register as such with a private physician or at regional clinics and receive legally prescribed drugs when and as necessary.

"Actually", emphasized Dr. Sadove, "under similar circumstances the amount of drugs that might run $200 and up if purchased from a peddler . . . would cost only about 12½ cents if administered clinically. We'd end up saving ourselves a big expense and a lot of heartaches. Individuals addicted to narcotics tend to be peaceful and non-belligerent. If they are aggressive or hostile . . . it is usually when, out of desperation, they have been forced into taking criminal measures to obtain the wherewithall to purchase drugs illegally."

"After all," concluded Dr. Sadove, "both bad habits and addictions are born from some kind of need. Perhaps when we can solve the reason for that need, we will be on our way to at least partial solution of the actual problem."

"But until then," he finished, "I suggest we quit treating these individuals as criminals and simply handing them over to the police . . . without first trying to treat them as human beings who desperately require our understanding. I contend that regionally supported inpatient clinics and carefully controlled prescriptions are at least one step in the right direction."

Problems in Medical Practice

The New York Academy of Medicine will sponsor a course on "Emotional Problems in Medical Practice" starting October 22, 1962. It will meet once a week for fourteen weeks. Each meeting will be a one and one-half hour seminar.

The registration fee is $20. For more details, write to the New York Academy of Medicine, 2 East 103rd Street, New York 29, New York.

N. J. Surgeons to Meet in Puerto Rico

The New Jersey Chapter of the American College of Surgeons is meeting in Puerto Rico February 17 to 24, 1963. A package plan has been prepared which includes round trip jet between New York and San Juan plus seven nights at a hotel in Puerto Rico. All-inclusive prices range from $200 to $250 per person in a double room (or $223 to $330 in a single room). A three-day extension to the Virgin Islands can be arranged at little extra cost. Travel is routed by the Smith Agency at 1115 Third Avenue in Spring Lake, New Jersey, which will send further details on request.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Relief of Symptoms. Walter Modell, M.D. Ed. 2. St. Louis, 1961. Mosby. Pp. 375. ($11.50)

In only 375 pages, Dr. Modell has packed a vast amount of usable information about the relief of symptoms. It has been shown that a short list of 27 symptoms includes 95 per cent of the complaints which bring people to doctors. The relief of symptoms, even when the cause is unknown or untreatable is an important part of practice. Persistent distress may start a stress syndrome, aggravating the basic illness. Relief of symptoms makes the patient more accessible to basic therapy. The spectrum of symptoms runs the alphabetic gamut from anxiety to unconsciousness. More pages are devoted to the relief of pain than to any other symptom. For the most part, Dr. Modell concentrates on therapy by drugs. Also included is a useful little monograph on drug therapy in general. It seems likely that the practitioner who owns this book will have frequent occasion to consult it.

Ulysses M. Frank, M.D.

Strong Medicine. Blake F. Donaldson, M.D. Garden City, N. Y., 1961, Doubleday. Pp. 244. ($3.95)

"Office practice," writes Dr. Donaldson, "resolves itself into the treatment of obesity and its complications in 30 per cent of cases; and 65 per cent complain of allergic manifestations." Thus, by controlling obesity and its complications (which include diabetes, gall stones, arthritis and many forms of cardiovascular disease) and by treating allergy, 95 per cent of all office patients can be properly handled. "We can practice about all the medicine that is worthwhile with six standard drugs plus a few non-standard ones," the author adds. Dr. Donaldson recommends writing down orders, and he prefers a rather authoritarian approach. "Never give an emotional patient a choice" he warns, "because, given a choice of two things, he will take four." For treatment, he suggests the diet of fat, meat and water, plus a demitasse of coffee. He is also interested in exercises and has diagrams showing exercises for arthritis. As for etiology, he has this to say: "It is our grandfathers who make us tick. More than any other factor in life, they color our way of thinking. Parents are merely the carriers of traits. An account of the four grandparents gives a clear picture of the patient and what he can expect by way of a healthy and successful life." As for his social philosophy, he expresses it this way: "Dispensary patients may be born failures with a tendency to fail at everything."

Henry A. Davidson, M.D.

Nursing Home Administration. J. D. Gerletti, C. C. Crawford, and D. J. Perkins. 1961. Downey, California (7601 Imperial Highway); The Attending Staff Association. Pp. 472. ($6.50)

Many a physician has dreamed of some day owning a nursing home, and quietly retiring on its income. Other doctors have been pressed into service as consultants to such institutions. To either physician this unusual manual will be of considerable interest. It consists of 84 intensely practical chapters running the gamut from how to get along with your medical staff, to how to handle the laundry; from how to live under administrative tension to how to keep good financial accounts. Although the book is an operational guide, it is also an excellent training manual for teaching employees and officers of nursing homes. It is a reference source, and an excellent springboard for discussion, brain storming and argument. Almost any chapter makes the agenda of a good conference. Thus this book could well be the framework for a course or seminar on nursing home administration.

Victor Huberman, M.D.

Medical Pharmacology. Andres Goth, M.D. St. Louis, 1961. Mosby. Pp. 550 with 52 figures and 220 structural formulae. ($11.00)

The swift advances of drug therapy threaten to make books obsolete almost as soon as they are printed. As a result, the better-known texts are being reprinted, or issued in new editions as rapidly as the authors can organize the material. *Medical Pharmacology*, however, is not a new edition, but a new book. It is shorter than the older texts, gaining compression by concentrating on concepts rather than on minutiae. Drugs in common clinical use are treated in conventional fashion—source, chemistry, pharmacology, side-effects, dose, and so on. The chapter on poisons and antidotes is a bit sketchy and curiously unbalanced. Thus, this entire section is only eight pages long and three of the eight pages are devoted to dimercaprol.

In his effort to produce a lean volume, Dr. Goth may have overcondensed. For instance, castor oil is disposed of in 3½ lines—a discussion, therefore, of little value to the practitioner who wants to know, let us say, contra-indications or the time it takes the oil to act. But the more modern preparations, like antihistaminics, tranquilizers and psychotomimetic agents, are adequately treated. On the whole, this is a handy desk volume for the practitioner, if somewhat inadequate for the researcher.

Abraham Leff, M.D.

County Society Reports • • •

Burlington

On March 8, the *Burlington County Medical Society* held its monthly meeting at Millside Farms in Riverside. Dr. Vincent Lathbury, Assistant Professor of Psychiatry at the University of Pennsylvania, gave an interesting talk on "Psychoneuroses Encountered in General Practice." The forty-four physicians in attendance responded well to the discussion and question period. The 1962-63 budget offered by Treasurer Murphy was accepted.

Dr. Bray discussed several aspects of the King-Anderson Bill, and recommended that letters be written by each doctor to his congressman, to transmit his own ideas about this proposed legislation.

Dr. Martin Goldfield explained a research project to be carried out in Levittown by the U. S. Public Health Department. This will be an effort to follow all acute illnesses of an infectious basis as to etiology and occurrence.

The *Burlington County Medical Society* convened in regular session at the Millside Farms in Riverside, on April 12, with President Ralph VanMeter presiding. Fifty physicians were present.

Robert S. Raviden, M.D., Assistant Professor of Surgery at the University of Pennsylvania, gave an enlightening presentation on chemotherapy in malignant disease.

Mr. Ellis, a representative of Stockwell-Knight Insurance Brokers, gave a brief discussion on liability insurance.

New members elected to full membership were: Drs. Thomas Honseknecht, Blebe Hayman, Harold Colburn, Ellis Hultzman, and John Strenski.

A resolution was adopted pertaining to the vendor payment plan of welfare boards, with the thought that it be introduced in the 1962 House of Delegates. Also discussed was Hudson County's resolution (requiring that the State Credentials Committee notify applicants when their applications were not acceptable).

JOHN ARBOGAST, JR., M.D.

Reporter

Middlesex

The annual social meeting of the *Middlesex County Medical Society* at Forsgate Farms Country Club, Jamesburg, was called to order by Dr. Thomas F. McLaughlin, the president, on May 9. There was a moment of silent prayer for our departed colleague, Dr. Charles E. Taber.

Proposed amendments to the Constitution and Bylaws introduced by Dr. Charles H. Calvin, chairman of the committee, were read and will be published.

A telegram and a letter were read from State Society President Ralph Buchanan, in which was presented the State Society's position on the King-Anderson bill. These forceful statements were well received. A telegram commending Dr. Buchanan was sent. This release will be published in the local papers at the expense of the county society, under the auspices of the public relations committee.

The Society's appreciation was extended to Mr. H. Miller, our host and representative of the Hoffmann-LaRoche, Inc., for the delicious meal and the splendid film on Librium®.

Afternoon golf was enjoyed, and those stalwart golfers were finally rewarded for their efforts. Dr. McLaughlin presented trophies to:

Low Man, Dr. Sokoloff, Score 85; *Second Low Man*, Dr. Brody, Score 87; *Third Low Man*, Dr. Copleman, Score 88; *Foursome Prize;* Drs. Akey, Score 94 and Sokoloff, Score 95; *Second Lowest Foursome*: Drs. Koenig, Score 96 and Brody, Score 87.

Thus ended a perfect day.

EUGENE L. CHILDERS, M.D.

Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday, April 17, at the Medical Society Building. Dr. David B. Levine, President, presided. Members of the Woman's Auxiliary were the Society's guests.

Elected to membership were: *Associate*—Dr. Arnaldo Apolito of Lyndhurst; *Active by transfer*—

Dr. Eugene Hrabarchuk of Nutley; *Active to Courtesy*—Dr. Eugene Gottlieb of Paterson.

Dr. Edward Wolfson, program chairman, introduced the guest speaker of the evening: J. Allen Yager, M.D., M.P.H., Director of the Paterson Department of Health. Dr. Yager's presentation covered his three-months' stay in the Congo. With illustrative slides, he portrayed the cultural pattern of Congo life as it evolves from the primitive into the complexities of twentieth century existence. Dr. Yager reviewed the medical care system and public health practices in the Congo. He reported on his visit with Dr. Albert Schweitzer.

This program was enthusiastically received. At its conclusion, a collation was served by Mrs. David B. Levine, chairman of the Woman's Auxiliary hospitality committee, and a social hour was enjoyed by all.

ALEX E. SCHEFRIN, M.D.

Reporter

Obituaries • • •

DR. ROBERT BUERMANN

On April 29, 1962, Dr. Robert Buermann, former chief of surgery at the Paul Kimball Hospital in Lakewood, died there after a brief illness. Born in Newark in 1887, he was graduated in 1911 from Bellevue, and then entered private practice in Newark. In 1917 he closed his office to accept a commission in the Medical Corps, and saw combat service in France, being cited for bravery in action. On returning from military service, he moved to Lakewood, and he served the people of that area from 1920. At Paul Kimball Hospital, he served in all grades, eventually becoming chief of surgery. He was a golden merit award laureate only last June.

Dr. Buermann was an FACS, a past president of the Ocean County Medical Society and a founding member of the Obstetrical and Gynecologic Society of New Jersey.

DR. EDWARD F. KLEIN

On May 15 this year, Dr. Edward Klein read a paper at our Annual Meeting. Twelve days later he was dead. Born in New York in 1895, he received his M.D. at Bellevue in 1919. After interning at Elizabeth General Hospital, he went to Austria for graduate studies. He then came to Perth Amboy where he did general practice for some years. Dr. Klein became increasingly interested in radiology, and acquired special training in that field. He was active in the affairs of the Middlesex County Medical Society and served as its president in 1949-1950. He had staff appointments at several hospitals in the county and, at the time of his death, was director of radiology at Perth Amboy General.

DR. C. PERCY LUMMIS

One of the oldest medical practitioners in New Jersey, Dr. C. Percy Lummis died suddenly at his home in Pennsgrove on May 14, 1962. Born in South Jersey in 1878, he won his M.D. at the University of Pennsylvania in 1901. He did general practice in Bridgeton for many years, and served the Bridgeton Hospital in all ranks, becoming chief of staff there in 1935. A few years later he returned to Pennsgrove where he practiced actively until the day of his death. In fact, his fatal heart attack occurred while he was in his office-home awaiting a patient. Dr. Lummis was a well-known amateur athlete and never lost his interest in sports. He was the first athletic coach the Pennsgrove High School ever had, doing this work as a labor of love in the early days of his practice. In 1957 he was a winner of our Society's Golden Merit award. He was long active in the affairs of the Salem County Medical Society.

DR. SAUL ZAGER

At the untimely age of 51, Dr. Saul Zager died of a coronary attack on May 25. Born in New York, he was taken to Newark as a child and attended the public schools of that city. He earned his M.D. at the University of Maryland in 1933 and interned at the Beth Israel Hospital in Newark. He did graduate work in proctology at New York Mt. Sinai and at the Polyclinic Hospital in New York. He limited his practice to proctology and was active in the work of the Essex County Medical Society. Some years ago he had a tour of duty as president of the New Jersey Proctologic Society. He was a member of the American Proctological Society, too, and was on the staffs of the Martland Medical Center and the Beth Israel Hospital in Newark.

*SCIENTIFIC EXHIBIT AWARDS

CLASS I—SCIENTIFIC EXHIBITS OF INDIVIDUAL INVESTIGATION, JUDGED ON THE BASIS OF ORIGINALITY AND EXCELLENCE OF PRESENTATION

First Place: Improved Results in Oral Carcinoma Using Precision Per Cone Therapy

S. Gordon Castigliano, M.D., and C. Ju'es Rominger, M.D., Misericordia Hospital, and American Oncologic Hospital, Philadelphia, Pa.

Second Place: Electronarcosis

Gene L. D'Alessandro, M.D., Jordan Zwetkoff, M.D., and Jesse Crump, M.D., Presbyterian Hospital Unit, United Hospitals of Newark, Newark

Honorable Mention: Angiotension — New Therapeutic Agent

Benjamin Jablons, M.D., Loreto S. Santiago, M.D., Mario Kolak, M.D., Agapito Del Rosario, M.D., and Paquita F. Manulat, M.D., Goldwater Memorial Hospital, New York, N. Y.

CLASS II—NEW JERSEY EXHIBITORS

First Place: Open Heart Surgery for Mitral Stenosis and Mitral Insufficiency

Henry T. Nichols, M.D., Dryden P. Morse, M.D., Gummersindo Blanco, M.D,. and Alberto Adam, M.D., Deborah Hospital, Browns Mills

Second Place: Cancer Detection by Immunological Methods

Jack G. Makari, M.D., Muhlenberg Hospital, Plainfield

Honorable Mention: Extra-Corporeal Circulation—Newer Applications

Ralph Lev, M.D., Paul B. Jennings, M.D., Estelle E. Kleiber, M.D., Diego DeArmas, M.D., and Barbara Leone, M.T., St. Peter's General Hospital, New Brunswick

*Announced at second session of House of Delegates, May 13, 1962.

National Bilirubin Survey

To stimulate interest in the accuracy of bilirubin determinations the College of American Pathologists announces a Bilirubin Survey, available to all physicians and hospitals. Bilirubin measurements are of great importance in decisions as to the need for exchange transfusion in newborn erythroblastosis fetalis. They are useful in the differential diagnosis of icteric syndromes at all ages. They are important in evaluating prospective blood donors. Poorly calibrated technic will lead to serious mistakes in the care of the patient.

Bilirubin measurements must be consistent from year to year so that treatment is based upon the same criteria in successive patients. Reliable bilirubin standards should be utilized with stable photoelectric photometers.

Participants will first receive a set of survey samples. Following the survey, a critique of bilirubin standards and methods of analyses will be provided. Questions arising during the survey may be directed to the Committee. If you wish to participate, please send $8 to the Standards Committee, College of American Pathologists, Prudential Plaza, Chicago 1, Illinois. Applications must be received not later than August 1, 1962.

Address of the Woman's Auxiliary President to the House of Delegates*

MRS. FLOYD D. GINDHART

My deepest thanks and appreciation to you, the members of the House of Delegates of The Medical Society of New Jersey, for this opportunity to come before you and bring official greetings from the Woman's Auxiliary. I do not feel as a stranger among you; rather I feel as one who has been working in close cooperation with you and your wives, the members of the Auxiliary.

This is the first and oldest Medical Society in these United States, founded before the American Revolution, organized before the thirteen colonies became Federated States. Of this you are cognizant, especially on this occasion of your 196th Annual Meeting.

When one is the oldest member of a family or society, one has a great privilege and prestige. There carries with that privilege and prestige, however, greater responsibility; more is expected of the first-born, since more of leadership has been given him than to all the others who may follow.

The members of the Woman's Auxiliary—your wives, the mothers of your children—stand willing and able to serve a cause that will preserve the freedom of all Americans. Will it take another Pearl Harbor to awaken all our people? Many of you were in uniform during World War II; so was I, so were many of your wives. Do you think for one minute that the women of the Auxiliary will not come together to meet the challenge?

Not one wife or mother is willing to raise her sons to be slaves, bound by shackles of ever-increasing and insurmountable taxation that stifle all ambition, initiative and imagination. New Jersey is hallowed ground, rich in the history of the battles fought by our forefathers for just such principles. The people are confused. There is no Paul Revere to come forward to sound the warning cry. There no longer rings the voice of Patrick Henry crying "Give me liberty or give me death." But the truth shall always keep men free. And now is the time for us to tell the truth. The cost will be small indeed, however great, once our fundamental freedoms have been taken from us as a people.

As I have traveled the length and breadth of this State during the past year, too often the question has been: Why has not some one told us the truth about the proposed plans for the so-called care of the aged under the King-Anderson Bill and other similar legislation?

The general public cannot learn that truth through our public press in this State, and that is the greatest sin of all and the cause of the tarnished image that is now falsely representing all members of the medical profession. We have been able to reach a handful while the propaganda machines of those who would destroy the very foundation of our American liberty have been laying down a barrage of untruths—insidious little lies that create doubt and make the doctor out to be a selfish, self-centered man interested only in amassing a personal fortune. You and I know how dastardly that lie is, but the sad fact remains that the general public do not know and therefore they accept the wrong side of the story. It is not entirely their fault that they do so, because until they have been told both sides of the story there is nothing for comparison.

I have said to you truth is the weapon and you in turn ask what recommendations I have to make. The answer is this: Since we are exposed to a biased press that will not present a clean and clear picture, we have to get to the people ourselves, even if we have to buy space in large quantities in a very short time to stem the tidal wave of misrepresentation now overcoming us.

The Woman's Auxiliary during the past year has done an outstanding task in raising funds for the American Medical Education Foundation, for the Medical Student Loan Fund for New Jersey, and for health careers; but unless we are able to live as free Americans without all our citizens totally dependent on a federal subsidy for their every need and desire, our efforts shall have been in vain. We shall have no applicants for the loans or the scholarships. Socialization of every facet of life could well sound the toll for the end of our civilization. It has happened nineteen times before. It can happen here. To prevent that tragedy, we of the Auxiliary offer to work with you without stint for the truth that must be proclaimed to keep us free.

*May 12, 1962—First Session.

Open Discussion on Medical-Surgical Plan

May 12, 1962

The Medical-Surgical Plan Discussion was convened at 4:10 p.m., Nicholas F. Alfano, M.D., President, Medical-Surgical Plan of New Jersey, presiding.

PRESIDENT BUCHANAN: I'm going to introduce and then turn this meeting over to the President of the Medical-Surgical Plan of New Jersey, Dr. Nicholas F. Alfano.

DR. NICHOLAS F. ALFANO: Thank you, Doctor Buchanan. I approach the honor of presiding at this session in the realization that it is well-nigh impossible for anyone else to bring to bear the wide knowledge and understanding, the ready perceptiveness, the facility of expression that have graced Doctor Schaaf's presentations of past years. Having enjoyed the benefit of his counsel, guidance and friendship for the last dozen years, I know full well how much of himself he has given, and gives, to the Plan and to all associated with it. I only hope that I can, in some small way, do credit to the dedicated example he has set.

This is an inspiring occasion for me. To many of you here, this marks the twentieth such session; but it is far more than that to me. Although I have been privileged to attend eleven previous meetings of this nature, this year I have the honor of representing Medical-Surgical Plan as its President and opening the session with a few introductory remarks. For that distinction, I am deeply grateful.

The presence of so many of you here represents a potential source of real strength in the future of Blue Shield. Indeed our success in creating more interest in Blue Shield within the medical profession depends entirely on the degree in which the individual doctors, represented by the encouraging number of you present today, can be brought together to share in the discussion and suggestions which, we hope, will lead to better understanding and solution of our mutual problems.

We have established a number of methods and avenues for keeping the profession informed on the operation and progress of Blue Shield. There still remains, however, much to be done to bring the profession in direct contact with the affairs of the Plan. The leadership and guidance of the profession were responsible for the creation of Blue Shield, and the direct participation of doctors on a continuing basis is the key to the future of Blue Shield.

Blue Shield is the doctors' plan. By that I do not imply a sense of ownership—as has been erroneously interpreted by a neighboring state agency—but, rather a plan conceived, sponsored and supported by doctors.

By your attendance at this session you are letting us know that you are interested in the further development of your Blue Shield program. Let us all respond by demonstrating in the course of this meeting and throughout the year in each of our local areas that we earnestly seek and sincerely want each individual doctor's full participation and cooperation in the development of Blue Shield.

Medicine today is subjected to social, economic and political pressures to a degree never before equaled. Special interest and political groups are seeking to establish concepts that pose a threat to our traditional patterns of private medical practice. Moreover, there are increasing demands that benefits be provided to special segments of our population by means of government subsidies. The extent to which medicine can meet those pressures with a practical and workable alternative through private non-governmental means, will determine whether medical practice as we have known it will survive.

Through Blue Shield we have the means of accomplishing any objective of this kind compatible with our system of medical care. We can meet every present and future challenge to private medical practice by utilizing the program that physicians themselves founded to help their patients finance the cost of care.

Today we must devise methods for providing care for senior citizens unless we are willing to stand aside and let government undertake the responsibility. And we must refine our program to counteract the efforts of special interest groups seeking to establish patterns of practice alien to our traditional concepts. In short, we must, through our Blue Shield program, be prepared to meet every economic and social problem involving medical care, because the future of our free medical system rests solely on our capacity to lead in the development of voluntary mechanisms to meet the health care needs of the nation.

To provide accurate and complete answers to a particular question, we have seated among us several of our Medical-Surgical Plan full-time personnel: each is expert in his particular responsibilities and functions with the Plan.

They will be called upon to assist in bringing you any information which may be required to satisfactorily meet your requests.

In addition to Medical-Surgical Plan personnel, we are fortunate to have with us Mr. Duane E. Minard, Jr., President of the Hospital Service Plan. Mr. Minard, would you take a bow, please?

(Applause)

And also from the Hospital Service Plan we have Mr. J. Albert Durgom, its Executive Vice-President, Mr. Durgom.

(Applause)

To Mr. Durgom's right we have the Medical-Surgical Plan legal counsel, Mr. Vanderbilt.

(Applause)

To the right of Mr. Vanderbilt we have Mr John Robinson, Administrator of the Plan.

(Applause)

Next to him is Dr. Rothgesser, Associate Medical Director; and Dr. Commando, Director of Physicians Relations.

(Applause)

And seated in the audience are three other full-time personnel: Dr. Nacca, Assistant Medical Director; and Mr. Franklin Romaine, our pub'ic relations officer; and Dr. Kimmel, Assistant Director.

(Applause)

And now may we have the first question?

Dr. William L. Palazzo (Bergen County): The Blue Cross Plan was recently granted an increase in their premium rates. This is to cover increased costs and it also, if I understand, is to cover some increased benefits. Among these benefits is radiation therapy in the hospital. I want to voice a definite objection to the coverage of radiation therapy, which is a medical service, in a Blue Cross Plan. I object to this personally; I object to it as a radiologist; I object to it as a physician who sees in this another attempt to cover a medical service with the Blue Cross Plan which is supposed to cover only hospital services. The answer would be to cover radiation therapy in the hospital under your basic Blue Shield contract. I know you have had objections to this before, but if this could not be done then it should be covered under your rider plan. Thank you.

Dr. Alfano: Blue Shield will consider making payment for radiation therapy administered in hospitals when there is no contractual relationship existing between the physician responsible for the administration of the radiation therapy and the hospital. Blue Shield must be assured that there will be no duplication of payment for the services; that is, payment by Blue Shield in addition to payment by the hospital under whatever contractual relationship exists between the particular doctor administering such services and the hospital.

Mr. Durgom will explain further why this has been included in the Blue Cross contract.

Mr. J. Albert Durgom: It is true that Blue Cross did get an increase in subscription rate, not to the extent to which it had sought an increase; however, in keeping the matter of the program of Blue Cross in balance financially but with whatever rate increase it did get for the shorter period of less than 20 per cent and it is still an underpriced product compared to our neighboring group plans. There are eleven other B'ue Cross plans in the country, of the million or more size enrollment, with higher rates. Our rate increase was a modest one and was not indicative of going over the lot, of including extra services, *per se*, in all of our contracts.

Radiation therapy was included as a coverable service in a new contract separate from that which some two and a half million people now hold. A new contract is about to be marketed at a separate price tag, if you will, for which this service would be available. There wasn't sufficient subscription increase in rate to include it in the others. We have *not* departed in Blue Cross from our established policy of dealing only with hospitals in relation to what is understood to be hospital services and for which the doctors do not bill the patients. Now let me read a letter from the Blue Cross president. It is dated April 10, 1962, to Dr. A. P. Dedick of Red Bank. Dr. Dedick had made inquiry of Mr. Minard and said that he was referring this to the proper channe's in the profession with respect to the matter of radiation therapy.

"The following is furnished in response to your inquiry relative to the inclusion among the benefits of the proposed expanded contract; that is, our new one to be launched in September, of coverage for our radiation therapy to the extent such services are provided on an in-patient basis in a hospital.

"You will recall that under the Blue Cross portion of Rider J hospital services for radiation therapy were covered only when such services are rendered in the out-patient department of the hospital, as ordered by the attending physician: and, quoting from the contract 'such services are customarily provided by the hospital and are billed for and payable to the hospital.' This leaves the sub-

scriber without coverage for such hospital services when rendered on an in-patient basis. This fact was recognized when Rider J was approved and the rider is rated accordingly. The Plan's current contract proposals filed with the Department of Banking and Insurance contemplate no change as far as Rider J is concerned in the area of radiation therapy.

"Plan subscribers hospitalized as in-patients are being provided radiation therapy services by the hospitals as ordered by their attending physicians. When such subscribers receive their statement from the hospital and learn that they are expected to pay for the radiation therapy services rendered in the hospital, they feel their Blue Cross coverage is incomplete in this respect. They expect Blue Cross to cover all the necessary services they receive from the hospital and in many cases they or their employers are perfectly willing to pay the premium for whatever cost the additional coverage involves.

Under these circumstances, coupled with the fact that in many instances in-patient radiation therapy is being provided and billed as a hospital service, it was felt that coverage for this service among the other added benefits in the expanded contract should be made available.

"It is important to bear in mind that under the new contract the Plan would cover only the services provided by the hospital and for which the hospital would make a charge to the patient."

I don't know, Dr. Alfano, anything to add because the letter was so self-explanatory and comprehensive in scope, and I felt it proper to read this letter since it is of interest to the profession.

Dr. John Winslow (Essex): What about *when* the therapy is started? I had a patient that had a week and a half of therapy. She was able to go home, then continue the therapy by daily visits to the hospital. Would this keep people in the hospital for the four weeks when they weren't really needed to be in, by having this kind of coverage, or could that be worked out so that it will be covered as an out-patient, back and forth business?

Dr. Alfano: When this patient returns to the hospital, does he come as a privately referred patient to the doctor? Does the doctor render his personal bill to that patient? Does the hospital charge for the services rendered this patient?

Dr. Winslow: The patient got a good bill to pay and I thought it was on the basis that the hospital was charging him. The patient didn't, of course, have this coverage now; but when she went home she was amazed to receive such a big bill for continuing therapy. I'm wondering whether this would be covered, since the hospital radiation department is still continuing the therapy. I'm wondering whether this will now cover that kind of a case or whether it tends to keep the patient in the hospital for a month so that she would be covered.

Mr. Durgom: I'm only a layman and I can't pass judgment on a medical decision. If the doctor decides that the person needs more radiation therapy and the person goes into the out-patient department and holds Rider J, then it is coverable under that rider. But if in his judgment the person needs in-patient care, I don't know whether it is necessary for the patient to continue in the hospital and thus prolong the stay just because Blue Cross covers it. But refer to the one basic element in Mr. Minard's letter: that our extent of coverage of radiation therapy in the in-patient department is predicated upon it being a hospital service as such, in that the hospital does the billing and the collecting; that the doctor isn't doing the billing in this instance.

If this were a matter where in a hospital it was not available as a hospital service but purely as a doctor service, then that's another matter and doesn't involve Blue Cross.

Dr. Alfano: If the patient returns to the out-patient department for continued radiation therapy and he returns as a private patient and the radiologist is permitted to charge that patient for the services he is rendering, then that would be covered if the patient is covered under Rider J.

Dr. John F. Johnson (Mercer): If Blue Cross and Blue Shield are completely separate organizations, why is it necessary that an individual have Blue Cross before they get Blue Shield? That's one question. My second query is this: why are subscribers billed in a lump for both services? This confuses them concerning the cost of both when the increasing cost is mainly in Blue Cross.

Third: in the case of a challenge on fee, please explain the procedure followed, especially when the difference is less than five dollars. Who can slice the baloney so thin?

Dr. Alfano: There is no requirement that a Blue Shield subscriber have Blue Cross coverage before he is permitted to enroll under Blue Shield. Either plan can be sold separately to any subscribers. A person may apply for either, for Blue Cross or Blue Shield or both. Anyone may apply for either coverage.

As to the reason for a single billing, this is a matter of economy. Much of our record-keeping is on tape now and we find it much more economical to bill both Blue Shield and Blue Cross premiums on one bill. Obviously, if we were to bill separately it would just double the cost. And when there is an increase in the rate of either plan, each sub-

scriber is informed by a letter that the rate of the particular plan which is increased then will be "X" dollars above that which he previously paid; so that every subscriber is informed of the plan for which he must provide a greater payment.

DR. JOHNSON: Suppose we repair a hand and send in a bill for $127. We get an answer back: We can pay you $124. Would you please explain how they arrive at this decision?

DR. ALFANO: Our payments are made in accordance with the schedule. We pay a physician in accordance with his charges up to, but not in excess of, the maximum fee in the schedule. If the schedule lists a fee at a certain amount and the doctor's charge is more, we can pay only the maximum amount listed in the schedule.

DR. JOHNSON: I have chal'enged a couple of these even though it costs more to challenge it than it is to accept it and have been supported in several instances. Who reviews the first form and decides that this is an overcharge? Is it done by a clerk? Is it done before the doctor is sent a letter? Does any doctor in the Blue Shield organization review this charge?

DR. ALFANO: Our adjudication staff consists of 15 lay individuals: mainly nurses and corpsmen, ex-Navy pharmacist mates, people who have had some training in medical matters, people acquainted with medical nomenclature. Any controversial claim is referred to one of the staff doctors. If there is still no solution, it then goes to the Plan's Fee Committee for review and eventually to the Board.

DR. JOHNSON: Do you think it worthwhile to challenge for a difference of five dollars?

DR. ALFANO: No. We would prefer to pay it. It costs us much more to carry on an exchange of correspondence between the physician and the Plan.

DR. LEVITAS: I spoke to you here not too long ago about this question of the Blue Cross experimental program taking care of patients at home and also in nursing homes and told you that I would probably have a resolution—it was put in this afternoon—about having Blue Shield go along with this experimental program of Blue Cross. The public is confused enough with plans that exist that they can't distinguish between Blue Cross and Blue Shield, neither can many of the doctors, for that matter.

Take a person, put him in a nursing home on a two-for-one basis or at home for a three-for-one basis. If you are going to prevent overcrowding hospitals even in a small way, it would seem to me Blue Shield must go along with this experiment if for nothing else to make it a good experiment, to make sense. So this resolution this afternoon was urging Blue Shield to get going. And why is it that the right hand doesn't ever seem to know what the left hand is doing? I happen to be one of the editors of *Medical Economics*. We are having an issue next month about hospital plans and health plans in the United States. It is an amazing welter of confusion. I know people in large organizations who are giving up the Blue Plans. U. S. Rubber gave up the plan. They can't deal with 96 plans. Sperry-Rand is giving up the Blue Shield and Blue Cross. Why is it that I have to put a resolution in to ask Blue Shield to come along with an experiment which would be very productive? Why doesn't the Plan do it?

DR. ALFANO: The Plan has gone ahead and is making a study of providing payment to the attending physician under the home care program which has been piloted by the Blue Cross organization. Our Board has authorized a joint committee of Blue Cross and Blue Shield personnel to develop recommendations as to how the Medical-Surgical Plan may cooperate in this pilot program with Blue Cross. It would be a parallel program with the Blue Cross organization. That is presently under study and a committee has been formed and is working on it right now.

We are having difficulty convincing the Legislature that we should have the right to offer a uniform contract to such organizations as you have mentioned, that is to national accounts. Today there are some plans that do *not* have legal authorization to enter into negotiations for the enrollment of accounts, the employees of which extend beyond the borders of the local area. Now there is legis'ation under consideration which would permit us to enter into these negotiations on a national basis so that there could be a uniform offering to a national account. It would obviate much misunderstanding and confusion among national accounts attempting to enroll in Blue Cross and Blue Shield and who, in desperation give up, and go to a commercial company, because each plan, as you know, is autonomous; it is under local control and until legal authority is given all Blue Shield plans to enter into these arrangements for enrolling national accounts, confusion and loss of national accounts will continue to exist.

DR. LEVITAS: What chances are there for this program for people over age 65? I refer to the convention recently held in Colorado. Do you feel this plan is probably going to go through? There were certainly riders written

in the last few days. This is going to be the greatest press release of all time, but nothing is going to be done; and if nothing is done after this promise this can hurt Medicine very, very badly. Do you think this is going to go through?

Dr. Alfano: Doctor, we have every hope that it will go through, but it depends upon you, the medical profession here. The program has been presented to the Medical Society. We are ready to approach the Department of Banking and Insurance for approval of a program. The original program as proposed by the National Blue Shield organization was one in which there would be *uniform benefits provided throughout the country*; there would be *a uniform national rate*. It would include a pooling arrangement and equalization of risk. The rate had been computed as to the cost for this particular senior citizens' program. There were objections by many Blue Shield plans. They indicated that the chances of its receiving approval by their insurance departments were very slim because of these features of equalization and pooling of the risk. The directors of the national organization have agreed that each senior citizens' program would be *locally* administered and each local area would compute its own rates; however, benefits would still be uniform throughout the nation.

Dr. Dear (Essex): Does the Medical-Surgical Plan initiate and investigate claims submitted by persons not administering the service? I'm referring particularly to anesthesia claims submitted by people who themselves have not administered the anesthesia.

Dr. Alfano: Yes. Several cases are under study now. Information was obtained that some claims were for services rendered by other than the physician billing the Plan. When that happens, we make an extensive study of the hospital records and attempt to obtain all corroborating information that the person who administered the anesthesia services was not the individual physician who billed us. We can't do it for every anesthesia claim since the administrative cost of investigating each case would be prohibitive. We undertake such a procedure when there is information or some indication that the physician billing us had actually not been the one who administered the service or rendered the services. We have discovered some such cases and we have been reimbursed. In fact, we have one right now in which we are negotiating for reimbursement of a large amount.

Dr. Dear: Do you suggest that the membership notify Blue Shield if they are aware of such incidents?

Dr. Alfano: Yes—We would appreciate it.

Dr. Dear: Are chiropractors paid for the administration of anesthesia?

Dr. Alfano: Yes. So are fully licensed osteopaths.

Dr. Dear: Is that because they are considered a part of the medical profession of New Jersey?

Dr. Alfano: Those osteopaths are fully licensed to practice medicine and surgery in our state.

Dr. O'Brien (Camden): Are there criteria for the extent of gastro-intestinal bleeding for which Blue Shield fees are paid? I call attention to three to four cases a year where we handle gastro-intestinal bleeders. In these cases x-ray studies are negative. Some have been to the hospital with frank hemorrhage, for whom we do not choose to give blood transfusions. If the doctor is honest, he signs the hospital chart out as bleeding of unknown origin. If one bills the patient for that hospital management, say, bedrest and low residue diet, the patient protests. If you send a bill to Blue Shield for that, it is rejected. By what criteria do you establish the certain grade of hemorrhage for which you pay? It is poor public relations on the referring physician's part, to have the patient protest vehemently that he was admitted to the hospital with frank hemorrhage and Blue Cross may not cover if x-rays are negative.

Now, we all know that there are certain gastro-intestinal bleeders. There are cases of diverticulosis which may bleed; and if I, alone, have three or four cases a year this must be rather extensive throughout the state. If these are being rejected for Blue Shield payments it hurts public relations. We do not want to be forced into automatically transfusing these patients, unnecessarily incurring certain reactions in order to abuse the Blue Shield situation, you see. I have in mind a patient admitted with frank hemorrhage. Of course, if a patient is admitted for frank hemorrhage, he expects to be treated and, of course, you treat him. You carry out your diagnostic studies and the diagnostic studies are negative. This then, of course, *post facto*, becomes a diagnostic case. But the patient admitted to the hospital for hemorrhage, stops bleeding and is discharged with the diagnosis undetermined.

I understand that this could be abused. You might get a thousand forms a week where the doctor asserts he treated gastro-intestinal hemorrhage, you see. If this patient was alarmed enough and the family was alarmed enough to see the patient admitted to the hospital for bleeding, he expects that his hospitalization

would cover, both his Blue Cross, and the physician's charge, so much per day for observing that patient during the hospitalization.

DR. ALFANO: I am unaware of any case that has ever been rejected because of frank hemorrhage. In the case that you describe, was there acute hemorrhage for which the patient was hospitalized? Or was the hemorrhage some time in the past, hospitalization being utilized to determine the cause for that hemorrhage some time ago?

DR. O'BRIEN: No. These are cases of frank hemorrhage admitted to the hospital with frank hemorrhage and rejected.

DR. ALFANO: I would ask Dr. Rothgesser to speak on that.

DR. ROTHGESSER: If we get a claim for a patient who had a frank hemorrhage, it's paid. I don't recall ever rejecting any who were admitted during an episode of frank hemorrhage. I would like to have each of those cases directed to my attention, by number and name.

DR. JOSHUA N. ZIMSKIND (Mercer): I had a patient sent to the hospital with what looks like a duodenal ulcer of some severity. The case is studied and the patient is x-rayed. All is negative. So they think it might be the gall bladder. You take an x-ray of the gall bladder and that is negative. The patient is treated for his symptoms and is discharged with a diagnosis of biliary disorder but with no specific thing that you can tie it into: no finding.

The doctor's bill is paid but the hospital is not. So the hospital bills the patient. This has happened twice that I know of.

Now, the patient was sick enough to come in the hospital. He is legitimately admitted. But he now has a bill for a couple hundred dollars. But hospitalizing the patient is just what you should do with any patient with those symptoms. They presume when they have Blue Cross and Blue Shield they are covered; but because nothing was found by x-ray, their bill was rejected by Blue Cross.

How do you determine the hospital should not be paid?

DR. ALFANO: If the Medical-Surgical Plan bill was paid in that case, it was an error. The contract is specific in both plans. Hospitalizations eligible for payment are necessary hospitalizations in connection with and consistent with actual prescribed treatment of the diagnosed condition. We do not question the need for the hospitalization in a case like that; but certain services are not eligble under both contracts. The question is not as to whether it is good or not good medical practice; that's none of our affair. All we do is to adjudicate claims in accordance with the terms of our contracts. Our contracts are very specific as to the type of case eligible for payment. You described a case in which the patient was admitted and certain studies were carried out which turned out to be negative. Since absolutely no treatment was rendered, we just can't pay that bill under our contract. Our rate is not computed to cover such types of cases.

DR. ZIMSKIND: In one case I know of, somebody came up and photostated the history and the progress notes. Treatment consisted probably of a little belladonna, phenobarbital and bed rest. Who is to say that's not treatment for it while we are looking to see what's going on? They were treated. They weren't just lying there just getting x-ray studies done. You say you are not interested in good medical practice. Well, I think you are, actually. We are and everybody else is.

The patient doesn't know all this. Just what would you consider treatment? What would you consider, we'll say, medical treatment if it weren't surgical treatment?

Now, I object to this very much. I got a letter with a statement like this: have you had any new findings? This is interfering with the private practice of medicine. I didn't think that anybody should tell me, because they have the patient insured, how I should treat the patient. And the patient is disturbed about the thing. Actually there was some treatment—not much because we didn't know what we were treating her for, but there was a definite condition present and this lady now has the bill which the hospital has sent her and the hospital should be paid for it.

Who is to decide whether the treatment was sufficient or whether it wasn't?

DR. ALFANO: It was for just that reason that the Plan requested the Medical Society to appoint an advisory committee of doctors on a State-wide basis to review these disputed claims; that is, claims which were in dispute between the Plan and a physician. This advisory committee has been appointed and they know the contract terms of the Plan. You indicated that we are not interested in medical practice. Well, if I said that, I didn't intend to. I mean that we do not question whether it's good or not good medical practice to admit a patient of that nature to a hospital for certain studies. But under the contract we are not permitted to pay for every hospital admission. Before a claim is declined, the Plan communicates with the attending physician and asks him certain questions, and later, if necessary, gets photostats of hospital records to determine whether there was actual treat-

ment. When the Plan feels that the provisions of the contract have not been complied with, the claim is declined.

Dr. Zimskind: On what does he base his idea of whether the treatment was carried out? Here a person was sent in for a gall bladder 'esion, we'll say, or an ulcer. This was sent in for gall bladder. Her gall bladder was negative.

Dr. Alfano: Then there was no gall bladder treatment.

Dr. Zimskind: All right. The gastro-intestinal tract was x-rayed and that was negative. Now, the patient was in the hospital, away from work. He was sick enough to be in a hospital. People do not go into the hospital just for the fun of it. And after thinking she is covered by this insurance, she gets this letter. I wrote a letter saying I thought she had not been treated fairly, and I still don't think she was. But now I have this letter saying they are going to refer this to the advisory committee to see whether they want to pay this lady's bill.

Dr. Alfano: The advisory committee reviews these claims to determine whether actual treatment was rendered during that hospitalization. But they do not determine whether the payment should be made. Perhaps Dr. Rothgesser will comment on that?

Dr. Rothgesser: Before a claim is acted upon by Blue Cross or Blue Shield, we assemble photostatic copies of the history, progress notes, orders, nurses' notes, frequently a physical examination, as much of the chart as we can conveniently get.

The usual story is this. The patient is admitted not acutely ill, not confined to bed, given a few oral medications. Several x-rays are taken. The patient is up and about. The nurses' notes show no complaints. A case like this is declined.

If the attending physician protests, then the Plan is no longer acting as judge and jury on its own decisions. The Plan basically has to make the original decision as to whether anything is eligible under its contract. If the physician still feels that the Plan has been unjust and so notifies us, we turn the file over to the advisory committee set up by The Medical Society of New Jersey. They advise the Plan whether our actions have been justified or not.

If you have such a letter and you want your claim reviewed by the special committee of the State Medical Society, just sign the letter and send it back and it will be so reviewed.

Dr. Commando: You made the statement that letters of inquiry sent as to what was done for the patient was interference with the practice of medicine. The Plan does not interfere with the practice of medicine. The evidence, up until that letter has been sent out, is for rejection of the claim. The letter asking for further information is to see if the physician can add any more data to validate the claim. We are not looking for evidence to reject it. In our mind, that claim is not justified for payment. When that inquiry is made, it's to see if there is something that does not present itself on paper so that the claim might be accepted. These questions are not asked with the intent to interfere with the doctor's free treatment of his patient.

A Doctor: If a patient is brought to the emergency room of the hospital shortly after an injury and x-rayed, are the Blue Cross and Blue Shield Plans responsible for the cost of the x-ray and the cost of emergency services the hospital itself may render? Is there any necessity to have a positive diagnosis like a fracture show on the x-ray to substantiate this claim? Is it necessary that the patient be admitted to the hospital to substantiate the claim? Assume the patient was injured, say, within a few hours or 24 hours of the time that they showed up in the hospital emergency room.

Dr. Alfano: Blue Cross would cover that. The Blue Cross contract covers emergency services in the out-patient department.

The Doctor: This is not listed as a diagnostic study and there is no question of whether they have to have Rider J in order to have this?

Dr. Alfano: Not as long as it's in connection with an accidental injury.

The Doctor: So if I send a patient with an accidental injury down to the emergency room and they have Blue Cross, I can tell tell them your Blue Cross will cover the emergency x-ray.

Dr. Alfano: Yes, as long as Workmen's Compensation is not involved, it would be eligible under the Blue Cross contract.

Dr. Edward P. Chappen (Mercer): Because of the great demand put on the hospitals for beds, we try to do as much work as we can on an out-patient basis. Maybe we could work out something where we wouldn't have to put a person in the hospital to do a study. I'm speaking of a woman who had ulcer type symptoms. She didn't seem sick enough to be put in a hospital bed. I ordered an upper gastro-intestinal series and it disclosed an ulcer. Besides the ulcer it showed cicatricial scarring which caused 60 per cent of the barium to be retained in her stomach. Obviously this lady was developing an obstruction. So within 24 hours she was admitted.

When she paid for her upper gastro-intes-

tinal series there was no need to get another such series while she was in the hospital. It would be a good idea in instances like this if we could put the charge for this particular upper gastro-intestinal series on the bill along with her hospital admission.

MR. DURGOM: There is provision for diagnostic services to be available without becoming an in-patient. If he holds Rider J, he may have certain diagnostic procedures worked up outside of hospital, as defined and directed by the attending physician; or he may direct this patient to the out-patient department for such services. Now there has been under advisement and some experimentation undertaken elsewhere, with some problems administratively involved, whereby instead of a person going right into a bed immediately and undertaking the diagnostic procedures and continuing in the bed, as I understand your question, for the necessary treatment after the diagnostic determinations, there is the problem of just how the gap, where the overflow will be, whether there is going to be any treatment following that diagnostic procedure while the person is in the in-patient department. Some-plans—Philadelphia has tried it, to have some work done, make ready, then the operation takes place in the in-patient part of the hospital at a certain time. That phase is under study.

But the first part of your answer is, there is definitely available now a means for care without going into the hospital bed.

DR. CHAPPEN: But this lady was admitted and she did have to undergo surgery. She had paid for her x-rays. The Blue Cross is not going to compensate her for her payment.

MR. DURGOM: Did the surgery take place promptly while she was still an in-patient?

DR. CHAPPEN: Yes.

MR. DURGOM: Well, we'd like to have her name and run down the details. If a patient gets a gastro-intestinal series in bed and immediately is operated on by the doctor, that's all part of the in-patient coverable Blue Cross service.

DR. CHAPPEN: That's what I want.

DR. WINSLOW: Mr. Durgom referred to x-ray as an out-patient; then the patient had to be admitted on the basis of that x-ray, and the x-ray wasn't paid; yet when we send somebody into the hospital, the day before they will often have laboratory tests done and that is billed to Blue Cross. Why was it not the same way with this?

DR. ALFANO: Diagnostic x-rays in the out-patient department, unless in connection with an accidental injury, are *not* eligible for payment and provided that Rider J coverage is not available to the particular individual.

DR. WINSLOW: What are Blue Shield and Blue Cross planning to do if HR 4222 passes? Will they be losing a lot of membership? And what are they doing in countering the Administration's publicity for this?

DR. ALFANO: No coverage of physicians' services is contemplated under the King-Anderson Bill; so that in effect Blue Shield is not involved. What effect that may have on Blue Cross coverage, I can't say.

MR. DURGOM: We don't know what the program is going to be in Washington. So there is no basis on which to anticipate what the effect will be on Blue Cross and Blue Shield without knowing what the other product is going to be.

DR. ALFANO: The coverage proposed under the King-Anderson Bill doesn't compare with the inclusive services offered by Blue Cross under the present contract. Those who can afford to buy Blue Cross will continue to be covered by it.

DR. ALEXANDER H. FISHKOFF (Middlesex): I wish to come back to the question of third-party liability multiple insurances, and medical payments. Last year I went to Trenton to meet with the representatives of the State Banking and Insurance Department. I went over this and the attitude they had was that of a protective mechanism. The Banking and Insurance Commissioner is out to protect the injured, the ill and the maimed; but they are open to any suggestion that we might make. They wanted something concrete. Hospitals are very much interested in this phase also and the Banking and Insurance Commissioner is reluctant to go along with an exception on one side and not with the other. I think they would go along with something if we could actually go over there in more detail.

A certain number of doctors—they may be in the minority—haven't joined the Plan, or have resigned from the Plan for this reason; these include orthopedists, general surgeons and some of us in other specialties. Last year my son joined me in my practice and his first question was: "Will I join the Plan?" I said, "By all means." He said, "What benefits will I derive from the Plan?" I went over that. Then, when the situation came up about third-party liability, multiple insurances and also medical fees as far as liability is concerned, he said, "Ho ho. I'm not going to join the Plan because of that." But I insisted and he did join the Plan.

The time has come now, with all the burdens that you have, and you are going to be

burdened plenty in the future, that this phase of it be reconciled so that the few physicians who are affected by this will join the Plan. As a matter of fact, I have learned that these few physicians who are involved partake of the Plan's payments to no small amount. They do take a lot of money from the Plan, so let's get them into the fold.

DR. ALFANO: Last year you asked the same questions and I told you that we had done something about it. You recall the Dumont Commission hearings a couple of years ago. The members of the Commission specifically asked us to submit to them any recommendations which we thought might improve our contract, and one of the recommendations that we submitted to them was this matter of third-party liability. Certain legislation was proposed concerning third-party liability and it is now under consideration. Now, what will happen to that, I can't say at this time.

DR. ROBERT WILSON (Passaic): I'm going to return with my same question, which is with regard to x-ray services following an accident, which I just discussed with a radiologist. He characterized you gentlemen as a panel of experts who didn't know what you are talking about—this is not mine but his statement—because, according to him, he has written to the Blue Cross and Blue Shield Plans on many occasions and has been told that if a patient is injured, sent to the emergency room of a hospital which has a radiologist attached to it, that this is often labelled as a diagnostic service and payment is refused. On occasions I think he is right because I've seen these letters come through where payment is refused. Is there any way of twisting the wording of the contract so that if a patient is sent to the radiologist in the hospital for an x-ray following an accident, that payment will be refused for this service?

DR. ALFANO: We are not considering Rider J in this at all. Am I correct?

DR. WILSON: We are not considering Rider J in this at all. And remember, this is an outpatient service associated with an accidental injury. It involves x-ray by the hospital radiologist, billed on his letterhead because in most hospitals the radiologist services are billed on the radiologist's letterhead.

DR. ALFANO: Then this would *not* be covered if Rider J is not available to that patient. If this is his own privately referred patient and the hospital permits this radiologist to accept privately referred patients and he may utilize the hospital facilities, then there they would not be covered since x-rays are specifically excluded in the Blue Shield contract, and Blue Cross does not make payment to physicians.

DR. WILSON: Suppose this kid had a broken arm and you went ahead and treated this broken arm. Is that radiologist's fee covered when you sent this child down with this broken arm, with an obvious diagnosis of a broken arm but you have to take the x-ray to find out exactly where it's broken?

DR. ALFANO: No. Now we are back at Blue Shield again. We would pay for the surgical treatment rendered. But we would not pay for the x-rays. That's a specific exclusion from the contract, unless Rider J coverage exists.

DR. WILSON: So if I have a patient with a broken bone and I send him down to the hospital, I have to tell him specifically "when you have this x-rayed as part of your treatment, you are going to have to pay the radiologist's bill yourself."

DR. ALFANO: That is correct, if that radiologist is not performing those services for the hospital as part of the hospital services.

DR. WILSON: But he is the same radiologist. He doesn't have a green and blue hat! It's the same fracture. It's not a diagnostic fracture one minute and a treatment fracture the other.

DR. ALFANO: It's very simple. Payment by Blue Shield would *not* be provided in that case because the contract specifically excludes x-ray services. And if this doctor is treating that patient as a private radiologist, this patient is not registered as a hospital patient, out-patient or in-patient or anything of that nature.

DR. WILSON: But suppose treatment is given in that same hospital and there is an emergency record that a fracture is reduced. Treatment is given by the same doctor who asked the radiologist to take the picture.

DR. ALFANO: Well, if the treatment is rendered in the hospital out-patient department, by a doctor other than the radiologist, Blue Shield would pay that doctor. However, the radiologist would not be paid. To be sure, if the radiologist is performing those services as part of his contract with the hospital; then the Blue Cross would pay the hospital but not the radiologist.

DR. WINSLOW: How many hospitals have contracts like that with radiologists?

DR. ALFANO: Since Rider J came into effect, the number of hospitals which are permitting radiologists to receive privately referred patients and utilize the hospital facilities is increasing. Up to the first year, only four such hospitals had granted the privileges to the radiologists to accept privately referred

patients; but that has increased now to about 13 hospitals which permit the radiologist to accept privately referred patients. These radiologists are now paid by the Blue Shield where Rider J exists. This is just what the radiologists wanted for years. And since we have had Rider J in effect, the radiologists are being paid directly by Blue Shield. Their argument has been in the past that the radiologic benefits should be transferred from the Blue Cross to the Blue Shield contract; but that could only be done under such circumstances as I've described where the hospital permits the radiologist to accept privately referred patients.

Dr. Fishkoff: Would you express an opinion as to whether this Rider J has worked out to the point where eventually you may permit some operative procedures in the doctor's office without Rider J as we do in the out-patient up to $50 worth of surgery.

Dr. Alfano: It is possible that such an extension of benefits may occur in the future but there is no contemplation of it at this time except under the extended surgical rider. We haven't acquired sufficient experience as yet. Our experience thus far, however, is increasing insofar as utilization of the benefits under the particular riders; but it is still too soon for us to determine whether there is going to be so much utilization that we might have to consider the rate as adequate or inadequate.

Dr. Winslow: May I ask the cost of Rider J?

Dr. Alfano: $2.17 a month for a full family and that provides 365 days of medical services in hospital.

Mr. Durgom: Although Rider J has been on the market for only a brief time, there are already 119,000 persons covered among 675 companies where the premium is being borne either in total or in part by the employer. This is the extent to which we concentrated at the outset on the marketing of Rider J to establish a reasonable foundation or base on which to get experience.

Then, too, in the auto industry, because of conditions peculiar to their programs, including a long-term program of benefits between management and labor, in the auto industry there are some 81,750 persons covered under Rider A.

Then there was Rider B offered by Blue Shield for the extra medical days. There are 15,262 persons covered under that. And there is Rider C for surgery out of hospital; and for that 7673 are covered.

So, all told there are 264-odd-thousand persons covered under one form of rider or another, of which over half now, almost half, are covered by Rider J as the most comprehensive.

Dr. Wylly: Do you plan to extend Rider J to individuals as well as groups?

Mr. Durgom: That, Doctor, is one of the resolutions brought up last year. Because of the shortness of the exposure of experience under our present operations, we felt it would need to be studied. We do not feel that we have sufficient experience to expand the sale to the non-group area because among individuals that type of market is entirely different because it's not a mass production marketing as it would be in industry from the figures you have seen. It would be a selectivity and therefore an entirely different exposure and we need to know more about our present risk at hand to the exposure to industry before we embark. But the answer is not no and yet the answer cannot be yes as of today, sir.

Dr. Wylly: Dr. Palazzo, at the opening, objected strongly to the new Blue Cross proposal to extend benefits to coverage of radiotherapy in a hospital since he felt that this is a medical service and not a hospital service. He wondered why Blue Shield allowed Blue Cross to extend this coverage. Every physician in this room and in this Society feels that this is a medical, not a hospital service. You answered by reading a letter from the Hospital Service Plan. But I would like to know how do you feel about it? Do you not think that the Blue Shield, the doctors' plan, should assume this coverage and turn to their sister plan and say: "This is our province; keep out of this." I'd like to know how you feel. I'm really not interested in that letter from Blue Cross. We know how they feel.

Dr. Alfano: Our Board has indicated that when the relationship of radiologists in hospitals becomes such that all patients are treated identically; that is, all patients are billed by the radiologist associated with a particular hospital; where there is no discrimination as to their method of billing as to whether the patient carries Blue Cross, Blue Shield, commercial insurance or is a rider patient, then the Blue Shield will consider making payment to the doctor directly, just as there is no financial relationship with the radiologist and the hospital in that there may be a duplication of payment if Blue Shield were to make payment for the services rendered for that radiation therapy and Blue Cross make payment to the hospitalization for the same services.

Dr. Wylly: But since you realize full well that this is a medical service, you should turn to your fellows in this insurance business and say: "Now, you are stepping in our province.

We are paying those bills. Don't you pay them." To me that would seem to be a very simple bookkeeping matter; and as a result of a simple bookkeeping matter you are really striking at the very heart of the practice of medicine. This is important. And I would think that we get over the bookkeeping end of the thing and realize what the essence of the thing is. The essence is this: hospital service is paying for a medical plan. That is wrong! It is time that you had this thing out with them. Please get them straightened out on this and stop this continual: well, we don't know; we don't want to have a double coverage and so forth. What they are doing is wrong. You said it's wrong. You know it's wrong and your Board knows it's wrong. Let's do something about it. You will certainly make the doctors in New Jersey feel better about it.

DR. ALFANO: Over all the years before Blue Cross and Blue Shield ever came into existence certain radiologic and pathologic services were considered hospital services. Have you or a relative of yours ever been hospitalized?

DR. WYLLY: Yes.

DR. ALFANO: Then you must have had an opportunity to review or see a hospital bill some time in the past, and I know that I have had some one hospitalized, and on this hospital bill was listed—the bill was payable to the hospital—was listed laboratory services, x-ray services for which my check was made out to the hospital and I paid the hospital and this has been something that has been going on from time immemorial as far as I know. It is not something to blame on Blue Shield or Blue Cross. It's just been an evolution of the practice of medicine that certain types of practices were in hospital, under the control of the hospital perhaps, charged for by the hospital. Doctors went in there voluntarily and made certain agreements with hospitals to render their services. Don't ask Blue Cross or Blue Shield to solve all these matters. It's the medical profession that should solve that. It certainly wouldn't make any difference for Blue Cross to eliminate radiology and pathology services just as long as it didn't have to pay the hospitals for such services.

DR. BORSHER: By resolution of the Board of Trustees of both the Medical Plan and Hospital Plan and of the House of Delegates of The Medical Society of New Jersey—this goes back over years—the services of radiologists, pathologists or physicians are medical services. However, there are individual radiologists and pathologists who have contracts with hospitals for rendering hospital services and these hospital services include radiologic and pathologic services. Now, to the extent that there are no contracts with hospitals by individual physicians to render these services as hospital services, they are medical services and can be paid for by Blue Shield when there is such coverage.

Neither Blue Shield nor Blue Cross nor the Medical Society nor the specialties can interfere with the individual contracts of physicians with hospitals for rendering services and their contracts with the hospital is *not* to render the medical service as a medical service but to render the medical service *as a hospital service*. When that medical service is rendered as a hospital service under the contract with the hospital, then it is considered a hospital service under the Blue Cross contract and it cannot be paid under the Blue Shield contract. As a purely medical service in which no contract with the hospital is involved, it can be paid by Blue Shield if the coverage is there.

So the problem comes down to the contract of an individual physician—in this instance the radiologist—with the hospital for rendering medical services which are hospital services under the terms of his contract. And that it isn't until we get this particular understanding that we can understand the involvement of Blue Shield and Blue Cross in the matter. As soon as individual contracts of radiologists and pathologists with hospitals have been changed so that they are rendering medical services, then they become eligible for payment by Blue Shield. But so long as they have a contract with the hospital to render these medical services as hospital services, *nobody can interfere with that contract,* whether it's Blue Shield or Blue Cross or the Medical Society or the specialty society.

DR. WINSLOW: Are the radiologists buying all the cobalt equipment and renting space in the hospitals? Do we end up with double billing? Does the radiologist bill for the diagnosis and the hospital bill for the patient using the space and the machine?

DR. ALFANO: Basically you have hit upon the reason why, perhaps, many radiologists may enter into these contracts with hospitals because of the cost of the equipment to establish their own private offices. But with the situation as it exists, we have no alternative but to deal with the problem as we are.

Well, it seems there are no further questions, gentlemen. I would like to thank you for your attention and your participation. It's been a pleasure to preside at this meeting.

(Applause)

(The meeting was then concluded at 5:40 p.m.)

Dinner-Dance

May 14, 1962

The speakers' section of the Dinner-Dance convened at 9:15 p.m., Mr. Richard I. Nevin, Toastmaster.

Mr. Nevin: That Mrs. Gindhart may have the privilege of welcoming you, may I have the pleasure at this time of presenting her? Mrs. Floyd D. Gindhart is President of the Woman's Auxiliary to The Medical Society of New Jersey. We extend to you an official welcome to the dinner this evening . . . Mrs. Gindhart.

(Applause)

Mrs. Floyd D. Gindhart: Thank you, Mr. Nevin. And thank all of you on this very wonderful occasion. I want to extend a warm welcome to all the members of The Medical Society on behalf of the Woman's Auxiliary. It has been my proud pleasure that you have extended a great honor to me during this very wonderful meeting. I shall not forget it. To Dr. Buchanan I say thank you, and I salute him.

I know that under these circumstances in this very beautiful room, this lovely atmosphere, we will all have a most gay and gracious time this evening. Please enjoy yourselves, enjoy your dinner, and the music, and all the entertainment that has been provided for you. It has been our pleasure to have you and to welcome you. Thank you.

(Applause)

Mr. Nevin: Madam President, Officers and Members of The Medical Society of New Jersey, Ladies of the Woman's Auxiliary to The Medical Society of New Jersey, Ladies and Gentlemen: I am truly delighted to be here with you. If you had, as we have, in the past days faced so many eminently antagonistic groups, you would realize what profound satisfaction or true delight is entailed in standing before a group and looking out at smiling faces and listening to friendly voices. It makes sweet music. That reminds me of Tennyson. Do you recall? After these days of travail,

> There is sweet music here that softer falls
> Than petals from blown roses on the grass,
> Or night-dews on still waters between walls
> Of shadowy granite, in a gleaming pass;
> Music that gentlier on the spirit lies,
> Than tired eyelids upon tired eyes.

And that is the music which we who have been listening to the sounds in the din of battle are rejoiced to enjoy with you here tonight.

Probably it is much more delightful for me to be here with you than it is for you to find yourselves confronted by me yet again. I am keenly aware, though sometimes my very gracious presidential friends seem to forget it, that, as some poet has said, even sustained rapture turns to pain.

As I go around with presidents year after year to the county society meetings or, indeed, appear here as Toastmaster, I find myself recalling a story of an Irishman who married a girl in his early days and subsequently in the province of God she died. And then after a time of proper mourning and loneliness, he married a second wife. He brought her home and he showed her through his place and took her to a closet upstairs and said to her "Bridget, I have only one wish to express. You see on that shelf that little hat? That belonged to my first wife, Kitty, and I should indeed be very happy if you would leave it there as a token of memory to her. I cherished her very much." So Bridget said, "All right, Patty, I will."

And after some years, in the wisdom of God, again the second wife died. And after a proper period of mourning and loneliness, Patty married again, this time to Ellen. And when he brought her home, he went through the same routine and he brought her to the closet and explained that there was just the one request, that she would respect his wish and leave these two little hats there, the one that belonged to Kitty, his first wife, and the one that belonged to Bridget, the second.

And she said, "I'll be glad to do that, Murphy, but there is one thing that you can be damn sure of. The next hat that goes in there will be a derby." I am not given to superstitions, but I am giving up wearing hats.

(Laughter)

It is one of my privileges as the Toastmaster at this dinner to make some introductions to you of those who are at the head table.

To my far left is Dr. John Torppey. He is the President of the Essex County Blood

Bank. He is a member of the Council on Public Relations. Mrs. Torppey said to me, "Don't introduce John as my husband." So I guess I shall merely say that he is not her husband, but she lives with him. I won't have her stand up now in her shame. I will return to her later.

(Laughter)

Of course, I don't need to introduce, or even now to present, but I'm happy to ask our new President as of this evening, Dr. Louis S. Wegryn, to stand and take a bow.

(Applause)

Next to Dr. Wegryn you will be surprised to discover is his gracious and generous and lovely wife, Edna Mae.

(Applause)

This robust fellow who is just one removed from me is officially the husband of the lady on his right. I won't introduce him as such, because he is a very distinguished member of the Mercer County Medical Society and The Medical Society of New Jersey, President of the staff of the Helene Fuld Hospital in Trenton—Dr. Floyd Gindhart.

(Applause)

The lady who is so enthusiastically clapping for him—for a perfectly obvious, hearty reason—I shall later on identify, if you don't know her already, as Mrs. Floyd Gindhart.

(Applause)

How shall I introduce the next lady on my right? I find myself thinking of—and you must let me incline to a little bit of quotation of verse tonight. I have been so damned down to earth lately.

For once he thrilled with high romance
And turned to love's eager voice.
Like any cavalier of France
He wooed the maiden of his choice,
And now deep in his weary heart
(And after this convention he can be pretty weary)
Are sacred flames that whitely burn.
He has of Heaven's gift a part
Who loves and is beloved in turn.

This is the state of our Guest of Honor, fortunate man that he is; and that maiden of his choice is the wife of his bosom and the mother of his children, named with beautiful and felicitous appropriateness—Grace.

(Applause)

The man next to her is Grace's husband.

(Laughter)

Next there is a lady who was a phantom of delight when first she gleamed upon my sight and whom time has but made the more dear—my wife.

(Applause)

One doesn't introduce the lovely Louise when her memory is so fresh and her presence so cherished from other occasions such as this—Mrs. Louise McCall—Mrs. Jesse McCall.

(Applause)

And, of course, you know Jesse—our debonaire, gifted, charming, gracious, effective and beloved ex-President.

(Applause)

We have in the audience some official guests whom I should like to rise that you may recognize them and welcome them. Dr. and Mrs. Daniel H. Bee, President of the Pennsylvania Medical Society.

(Applause)

Dr. E. Tremain Bradley, our always welcome delegate from Connecticut.

(Applause)

Dr. and Mrs. Joseph B. Forman. Dr. Forman is also a delegate from Connecticut.

(Applause)

They have with them a little bud from their personal garden, whose name I don't know, but I think she should be recognized.

(Applause)

Although I have not had the pleasure of meeting the lady, I'm informed, having heard her praises highly acclaimed by all who have had that privilege, that we have here tonight Mrs. C. R. Pearson, who is Treasurer of the American Medical Association's Woman's Auxiliary.

(Applause)

These are the official guests that I have had listings about. Subsequently, Dr. Buchanan will introduce the members of his family, and he will also introduce his personal guests since he knows them better than I do.

At this time it is my pleasure to call upon this fellow whom I so lavishly but sincerely praised before—Dr. Jesse McCall—who will present to Dr. Buchanan his Fellow's Key . . . Dr. McCall.

(Applause)

Dr. Jesse McCall: Buck, Ladies and Gentlemen, Distinguished Guests at the Head

Table: I think this is a dirty trick having to follow that sort of a presentation.

You know, I was prepared to come up and sympathize with you for all the trials and tribulations that Dick mentioned a moment ago in opening his remarks. It has been a rough year, apparently a rough 48 or 72 hours.

I won't point a finger of blame at any particular person. I would like rather to identify the fact that this job for which I'm going to really and truly personally reward an individual—this job of being President of The Medical Society of New Jersey is truly an onerous one; it's one of tension and continued work for which anyone deserves a greater reward than I'm going to present. It never ends.

Dick thought that he came here tonight to be relieved of some of the tensions of the past several hours, and after he had talked for about thirty seconds you recall there was an uproar at the end of the room. I was in a position—by the way, I'm just about to be bounced off the head table. I'm in the furthest seat, the furthest seat to the right—and I'm left-handed—that you can possibly get and still stay up here where you can be seen.

(Laughter)

Anyway, this uproar occurred. I looked down towards the entryway. I think we get our food from there; other chores are possibly accomplished there, too. But the thing that struck my eye as I looked in that direction was the figure of Dr. Bruce Henriksen. Bruce, where are you?

(Applause)

In order that you may not suffer the penalty alone, I will say that the voice that turned me in that direction and which I recognized much more promptly than yours was that of an old friend, Dr. Elton Lance, who was making most of the fuss.

(Applause)

More seriously, I would like to say that this is a special privilege of mine. It's a privilege that I think is accorded to the most immediate past-Fellow, if there is more than "the most," of the Society. It's awarded more by custom than it is by constitution, but it is a custom that I cherish. I'm glad we have established it, and it is a very special privilege for me. It is the custom of awarding the Fellow's Key to the guy who has suffered with us through this past year. He has plotted and has sailed a very fine course through very stormy seas. They have been very stormy the last few days. I'm glad, by giving him this particular key, to return him again to the family circle.

This, Buck, does not give you the privilege of retirement. It identifies all the work that you have done, but it gives you also the privilege of indulging further in service to The Medical Society of New Jersey, and I'm sure you are going to be called on for quite a long time to come.

With my heartiest congratulations and, I'm sure, those of our audience and of the State of New Jersey, really.

(Standing ovation)

President Ralph Buchanan: Thank you very much, Jesse.

I know that in all humility I cannot adequately express the appreciation that I would like to. I am told that this is not the time for me to give my hour and a half lecture. I am only to accept this key and graciously bow out so our Dick Nevin can come back to the mike.

Thank you very much.

(Applause)

Mr. Nevin: I return to the mike only to recall our newest Fellow, who is a jolly good fellow, to ask him to present now the Fellowette's Pin to Mrs. Gindhart, as the retiring President of the Woman's Auxiliary to The Medical Society of New Jersey.

Dr. Buchanan: Sounds like Mr. and Mrs. Shean here.

Mary, I know that you have had a hard year. I know that our paths have crossed many times, with and without your husband and my gracious wife. My pleasure at this time to give you the Fellowette's Pin in token of your work this past year. Well done.

(Applause)

Mrs. Floyd D. Gindhart: Thank you very much, Dr. Buchanan.

As we started out this year together, you said to me, "I shall be Mary and you shall be Buck." I had planned to say that now that we both have reached retired status and are not eligible for benefits under the King-Anderson Bill—but he said "We are not supposed to retire."

But thank you very much. I accept this with deep humility and appreciation, and I shall cherish it always. It's been my pleasure to serve and I shall continue to the end of my days in whatever manner you so desire me to do. Thank you.

(Applause)

MR. NEVIN: I knew he wouldn't do it. I defied him to pin it on her.

(Laughter)

For what I am now called upon to do I wish I had more time and I must throw myself with apologies and, of course, on my knees before Dr. Buchanan for not having been able to spend longer time in preparation than I would like to, to introduce him. I wasn't just wasting time; I was otherwise engaged.

Last summer I had the very great honor and privilege of being invited to Phillipsburg to talk to a gathering of the people of Phillipsburg who had come together with only one purpose—to do honor to a man whom they 'ove. And I discovered that this man—our Guest of Honor tonight, our retiring President—has a place in the hearts of all those with whom he lives and whom regularly he serves, because they know him to be what we have found him to be—a good man who is dedicated to high and worthy levels of service.

For a while I wasn't quite sure what there was about him that I found pleasantly attractive, restful; and then on reflection I realized that there is about him a certain serenity. He has Heaven's grace of heart who loves and is beloved in turn. We move into vexing situations and deal with very matter-of-fact things, but when Buck used to walk in and say "Hello," there was about him a certain aura of peace and simp'e serenity which I began to discover after that—to discover in the sense that I could explain it to myself—when I saw how secure he was in the affections of the people whom he served, and I understood it better when I knew Grace and had met his family. I understood it better when I was told something of the story of the Clan Buchanan; that he is the seventh of seven sons and that each boy in turn helped the other boy, because to carry a brother is not to carry a heavy load —because he is your brother.

We have in the past few days been trying to inspire something of the spirit of mutuality of devotion and dedication in the members of The Medical Society of New Jersey, so that in the spirit of the Three Musketeers and D'Artagnon—that's why I got the four in—they would live in the consciousness of the dedication of one for all and all for one, that they might better serve the true good of the people of New Jersey and of the country.

I think there has been in Dr. Buchanan's life an enrichment that comes of love and brotherhood, and since they are of the Clan Buchanan I can think of no better way of bringing my rather wandering remarks to a point than by letting Bobbie Burns take over and say in this significant hour:

> Then let us pray that come what may,
> As come it will for all that,
> That sense and worth o'er all the earth
> May bear the gree and all that,
> For all that and all that,
> It's coming yet, for all that,
> That man to man, the world o'er
> Shall brothers be, for all that.

The youngest of the brothers, who will introduce the others—Buck Buchanan.

(Applause)

DR. BUCHANAN: Mr. Toastmaster, Past-President Jesse, President Lou, Honored People at the Head Table, and you Distinguished Guests in the Audience: I realize that you must by this time be surfeited with conferences, discussions, presentations, and speeches of all kinds. For that reason I shall not long impose upon you here tonight.

One year ago this time I approached my duties as President of The Medical Society of New Jersey with humility and no small degree of trepidation—humility because of my illustrious predecessors; trepidation for my brashness in attempting to carry on their distinguished and learned tradition.

My formal report as President of The Medical Society of New Jersey was printed in THE JOURNAL and presented to the House of Delegates. Most of you heard my farewell address this afternoon, and I shall not try to reproduce it now. Permit me to refer to my formal report. In my opening paragraph—and I quote: "In the course of my year as President, I discovered that, although the years of service in the offices leading to the presidency give one a limited appreciation of the responsibilities and activities that confront the president, the presidency itself is an office that must be filled to be truly estimated or known."

No one person, human as he may be, no single physician within the State of New Jersey can fulfill said office without help and guidance. I have been brought to realize and appreciate, too, how much I am indebted, far more than words can adequately express, just how much I owe to the generous efforts of the staff at 315 West State Street.

Staff, will you please stand up and take your due bow? Thanks to them, they who are most able and capable, from Dick, from Edith, from Terrie, down the chain of command, my task was not as formidable as it might have been.

(Applause)

To all chairmen of the various and numerous councils and committees, to all presidents and secretaries of the twenty-one counties, and to all others who were active in the Society's function this past year, in my own name I express profound gratefulness.

Due recognition comes easy, as far as I am personally concerned, to many others in this room tonight. Accolades are in order to any of them. Should I inadvertently forget to publicly acknowledge all, please forgive me. I will personally shake your hand later.

There is so much to be said and so little time to say it. I wish at this time to recognize all my friends from Warren County. Would you please stand?

You may have felt that Warren County was a small county. You see it's extended back into the other table in the rear.

(Laughter and applause)

Due recognition has to be paid to our President, Hank, would you stand up and take a bow, please? And his lovely wife, Julie.

(Applause)

Singly coming out of Warren County you had the pleasure last year of having a fellow by the name of Dr. G. Homer Bloom, shall I say, expose me. Homer, won't you and Alice please take a special bow for me?

(Applause)

I have the pleasure here tonight to ask my sister-in-law, my brother-in-law and his lovely wife to stand and be recognized—Isabelle, Billy and Billy's wife, Irma.

(Applause)

I know not how many of you people had known that I was leading a double life in Trenton this past year. There is an office at 28 West State Street, in Mary Roebling's building, where the State Board of Medical Examiners have an office. We have with us tonight our Executive Secretary Dr. Vincent P. Butler and his gracious wife.

(Applause)

We have with us tonight, and I'm going to say it, our underpaid assistant that has the attack of a Richard Nevin, of an Edith Madden, and all the people at 315 West State Street—Mildred Lavine and her husband, Ben. Would you take a bow, please.

(Applause)

Now I come to a part where there is a group here that knows me probably almost as well as my beloved wife—my Office staff—and words at this time cannot adequately express my sincere appreciation, my devotion for the people that I am about to recognize—Mac McGinley, my registered nurse; Harry McGorigle, my x-ray technician and my medical technician and his lovely wife, Peg; along with Kathy and Rosemary. Would you please stand? These are my front-line attack; these have been my co-patriots; these have been my line of defense—and, brother, I do appreciate them.

(Applause)

You have heard Dick refer to my brothers. It has been my pleasure to have had six faithful, devoted brothers. In their order, from the senior man and his lovely wife Ella—my brother Dave, who is a registered pharmacist in the small town of St. Clair, Schuylkill County, Pennsylvania. Would you stand, please?

(Applause)

My other brother, who is retired from Breyer's Ice Cream Corporation in Philadelphia—Bill. Bill is here alone, unfortunately. His lovely wife, Ruth, cannot be with him. Would you stand, Bill?

(Applause)

And now, some families have twins. We have twins in the presentation of Dr. John Buchanan, dental surgeon, and his lovely wife, Marion.

(Applause)

His twin, although he was born on a different date—it so happend that midnight came in there—his brother Tom and his lovely wife, Kay. They have with them their daughter, Mary Ellen.

(Applause)

And then we have Jim. Unfortunately, we didn't have a table big enough to take care of all the Buchanans, so we had to split them up. Jim and his lovely wife Helen. Jim is also a pharmacist in East Falls, Pennsylvania.

(Applause)

And next, but not least, I have a brother Edward, who is a devoted school teacher in Bernardsville, New Jersey, and his lovely wife, Kay.

(Applause)

So as things progress, I'm coming down to a table which any proud father would be most happy to bring to the attention of you people here tonight. I think you met them last year; I think most of you met them again tonight. We have my oldest son, Bob, and his lovely fiancee whom my wife and I are most gracious to welcome into our family—Connie Waldman.

(Applause)

Now, the next three members of my family are the twisters—Peggy, Jane, and Dick.

And now comes a very happy ending. I wish what I was about to tell you is an original; however, I read it on a card yesterday when I was trying to find one for my lovely wife.

If hearts could talk, you can't be sure,
My loving heart would tell
The things you all too seldom say
But know so very well.
Like what a perfect wife you are
And perfect mother, too.
If hearts could talk, each beat of mine
Would tell you I love you.

(Applause)

Sincerely, in closing, in this year thus ended and in that work and in that spirit of The Medical Society of New Jersey which I have been engaged, in common with all other officers and workers, I regret that I could not have done more. I shall aways honor the key, a symbol of my being junior among all your other Fellows.

There is little more that I can say by way of thanks to you for this wonderful evening—one of the happiest and one of the most memorable experiences in my life.

Let me steal and adopt a line from Tiny Tim and say, For Grace and myself, from our very hearts, God bless you, every one.

(Standing ovation)

MR. NEVIN: Ladies and gentlemen, in my desire to allow the President-elect of the Woman's Auxiliary to regain her equanimity after the remark I made about her, I deferred introducing her at that time. I should like now to present the President-elect of our Woman's Auxiliary: Mrs. John Torppey.

(Applause)

I now ask Dr. Hermann, President of the Warren County Medical Society to come to the platform.

DR. HERMANN: Mr. Toastmaster, Doctor and Mrs. President, Honored Guests, Ladies and Gentlemen: I have been informed correctly, I hope, that the last time that the Warren County Medical Society came down here on such an occasion honoring one of our members as the outgoing President of our Society was sixty-five years ago. This seems to become a habit that we are here again tonight. At the rate we are going, our next date will be the year 2027.

(Laughter)

Dr. Buchanan, it is my privilege, as President of the Warren County Medical Society, on behalf of the members of that Society, to present you with this gift certificate as a token of our esteem, respect, and affection. I won't tell you what it is for, but pretty soon you will be engaged in an audible vast wasteland. Thank you.

(Applause)

DR. BUCHANAN: Thank you very much.

So this may not be a mystery, If I can read the good doctor's writing: "We owe you a portable TV set, to be brought to your home by your dear wife. Thank Ducky and the rest of the boys in Warren County."

Hank, through you to them I so express my thanks and appreciation.

MR. NEVIN: Entertainment is now to be furnished, as a tribute to a distinguished alumnus, by the Lafayette College Choir. I have had indications they are here, but this thing has to be set up for them. I think I shall withdraw and let them take over with the orchestra's assistance, and wish you all a delightful remainder of the evening. Thank you.

Official Transactions of the House of Delegates

196th ANNUAL MEETING OF

THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY, N. J.

MAY 12 - 16, 1962

NOTE TO READERS

The annual reports and transactions of the House of Delegates of the 196th Annual Meeting of The Medical Society of New Jersey are bound together in this issue of THE JOURNAL.

Actions taken by the House of Delegates are indicated in bold-face small type in the reports.

Attendance

The House of Delegates rolled up its best attendance ratio in our history when 91.3 per cent of the delegates registered in. Actually, we had an attendance of 411 out of a possible 450. Attendance at the first session was 81 per cent of the possible maximum and at the third session it was 89 per cent. At the second session, 95½ per cent of the registered delegation attended. Some additional figures follow.

With respect to total registration (not just delegates, but *all* who attended) we came close to the 1960 record of 1254 but didn't quite reach it. Here are the figures:

Year	Physicians	Others	Total
1962	1,208	1,083	2,291
1961	1,134	1,115	2,249
1960	1,254	1,307	2,561
1959	1,124	932	2,056
1958	1,193	950	2,143

County	Delegates	Members	Total
Atlantic	11	71	82
Bergen	44	25	69
Burlington	7	18	25
Camden	24	54	78
Cape May	3	6	9
Cumberland	6	15	21
Essex	90	158	248
Gloucester	4	10	14
Hudson	31	30	61
Hunterdon	4	6	10
Mercer	26	49	75
Middlesex	20	27	47
Monmouth	20	59	79
Morris	18	21	39
Ocean	5	13	18
Passaic	29	29	58
Salem	3	7	10
Somerset	6	12	18
Sussex	3	1	4
Union	38	47	85
Warren	3	6	9
Fellows and Officers	16	—	16
	—	—	—
	411	664	1,075

In addition to members, the convention registered 434 Auxiliary members, 47 Auxiliary guests, 101 physician guests, 32 physician exhibitors, 325 visitors and 277 general exhibitors for a total of 1075 members, plus 1216 others and a grand total of 2291.

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PRESIDENT

Ralph M. L. Buchanan, M.D.

(Reference Committee "A")

In the course of my year as President, I discovered that, although the years of service in the offices leading to the presidency give one a limited appreciation of the responsibilities and activities that confront the president, the presidency itself is an office that must be filled to be truly estimated or known. Perhaps the presidency's greatest demands consist not in one's being physically present at so many diversified meetings, but in his being constantly available for conference on items of concern to the Society, and meeting the responsibility of making day-by-day decisions that are in conformity with the policies and programs of the Society.

This has been a busy and a taxing year for all of us entrusted with the affairs of The Medical Society of New Jersey. Evidence of this is unmistakable in the number and bulk of minutes of the meetings of the Board of Trustees and of all the councils and committees of our organization. By and large, all the agencies of the Society have had an active and satisfactory year. Not in all areas can we claim equal progress, but, with real justice, I think we can say that we have given full and careful attention to all aspects of the Society's business and have made vigorous efforts to do our jobs as well as circumstances would permit.

We have, it seems to me, had some particularly good results this year in our contacts with other professional groups. For example, we have had the satisfaction of winning the Bar Association to an interest in the M'Naghten Rule as it might, in its application, be modified in the light of new knowledge concerning man's mental and emotional states. With the help of the Bar and the Supreme Court, at present, on a pilot study basis, in four New Jersey counties panels of impartial medical witnesses, supplied by the Society, are available to serve, at the call of the Court, "to examine and give testimony in cases in which there is marked divergence of medical opinion." This development represents the culmination of Society interest and activity in this matter dating back to 1948.

We have, likewise, maintained close and fruitful formal contact with the New Jersey Hospital Association, the New Jersey State Dental Society, the New Jersey State Nurses' Association, the New Jersey Pharmaceutical Association, the New Jersey Osteopathic Association, and—informally—with the New Jersey Optometric Association . . . all in the effort to serve the interests and policies of the Society as they impinge upon the areas of interest of these several groups. Many of the matters involved may be described as continuing "in process," but they are under investigation and discussion, under circumstances that safeguard mutual understanding and should lead to mutual cooperation.

As the result of a series of conferences participated in by the representatives of our Society and representatives of the New Jersey Blood Bank Commission and the State Department of Health, recently the Board of Trustees was able to approve a draft of legislation, evolved by the conferees and approved by the Council on Legislation, to "establish minimum standards for the control and licensing of activities relating to blood banking." It is expected that the legislation will be introduced this year, under the sponsorship of the State Administration.

Our efforts to achieve the rejection of national legislation that would indiscriminately supply limited health care services to Social Security beneficiaries over 65 years of age, by increasing taxes for all Social Security taxpayers, are familiar to all our members, in consequence of detailed informational materials supplied in conjunction with our recent statewide campaign. Probably no more important issue confronts us and all the American people. Unless each of us measures up to his responsibility as a citizen and a physician, and does all in his power to defeat this program—so strongly supported by the National Administration—the outlook for a free country or a free profession will be shadowy, indeed. Our members should realize that this is one battle which organizations as such cannot fight successfully. The threat is to the freedom and solvency of the nation and all its people. It is the duty, therefore, of each individual to do his full part in eliminating this deadly

threat to himself, his family, and his country.

My travels (of some twelve to fifteen thousand miles) and my contacts (through about 100 meetings, conventions, and conferences) have given me this year a full and accurate appreciation of the number and complexity of the programs and developments that must be dealt with by those who conduct the operations of The Medical Society of New Jersey. I have been brought to realize, too, how much we owe to the generous efforts of all who are active in either The Medical Society of New Jersey or its component societies. To all of them, in my own name and in the name of all our members, I express profound gratefulness.

The times are such as call for unstinting effort on the part of all who have talent and time to offer. I call upon all our members, therefore, to emulate those who are already actively at work, so that our united efforts may be expanded and strengthened, to the end that the full measure of good that we can—and therefore should—do may be realized.

Approved (page 439)

SECRETARY

Marcus H. Greifinger, M.D., Newark

(Reference Committee "A")

The office of the Secretary has continued its usual routines primarily involving correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the current administrative year the Secretary attended the annual meeting of the American Medical Association in New York City—serving in a dual role as the Secretary and also an AMA Delegate. At state level, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1960)

Active: Paid	6,118	
Exempt	295	6,413
Associate: Paid	396	
Exempt	49	445
State Emeritus		135
State Honorary		4
New and reinstated members:		
Active	217	
Associate	101	318
Transfers in-state		51
Transfers out-of-tate and resignations		42
Members deceased		83
Members dropped:		
Active (non-payment of dues)	38	
Associates not advanced to active status	17	55

AMA MEMBERSHIP

5,890 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates continued to total six delegates—one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

The 5th edition of the *Membership Directory*, 1961-62 issue, was published and mailed on September 1, 1961. It includes listings of all members in good standing in the Society as of June 1, 1961. As of March 31, 1962, 6,526 copies have been distributed to members as a benefit of membership, and 746 copies have been sold to hospitals, governmental agencies, cooperating agencies, and pharmaceutical and medical supply houses. The directory is a biennial publication, and the next volume is scheduled to be published in 1963.

Heretofore the publication of the directory has been the sole responsibility of the Secretary. Last fall the Board of Trustees authorized the appointment of a Special Committee on the Membership Directory to deal with policy decisions concerning publication of the directory. The Secretary is happy to have the assistance of a committee in dealing with this responsibility.

Approved (page 439)

TREASURER

Daniel F. Featherston, M.D., Asbury Park

(Reference Committee "B")

The administrative and fiscal year of MSNJ is June 1 to May 31. In the past the Treasurer has presented an interim report covering a period of from ten to eleven months of the fiscal year. It was suggested that the report cover a full twelve months even though two fiscal years would be represented. Accordingly, for the first time, the financial report covers the business transactions in the office of the Treasurer for the past twelve months and represents transactions of one month in the fiscal year 1960-61 and eleven months in 1961-62.

The following report, prepared and certified by the auditor, covers the accounts from May 1, 1961 through April 30, 1962:

BALANCE SHEET — APRIL 30, 1962

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$ 32,798.06	
Executive Office Revolving Account	10,000.00	$ 42,798.06
Savings Accounts:		
Asbury Park-Manasquan National Bank	$ 10,000.00	
Bloomfield Savings Bank	10,000.00	
First Camden National Bank and Trust Company	10,000.00	
First National Bank of Westville	10,000.00	
The Howard Savings Institution, Newark	10,000.00	
The Morris County Savings Bank, Morristown	8,050.37	
The Montclair Savings Bank	10,000.00	
Plainfield Trust Company	5,815.45	73,865.82
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$ 10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$166,663.88
Accounts Receivable		10,303.24
Inventory—Maternal Welfare Record Books (at cost) (contra)		4,637.50
Investments—U. S. Savings Bonds and Treasury Notes		195,430.41
Land, Buildings, and Equipment (contra)		148,997.69
Deferred Expenses		5,674.20
Total Assets		$531,706.92

LIABILITIES, RESERVES, AND SURPLUS

Employees' Payroll Deductions Payable	$ 1,306.38
Assessments Collected, Applicable to 1962-63 Fiscal Year	119,994.35
Unexpended Budget Reserve, 1961-62 Fiscal Year	49,981.07
Annual Meeting Reserve	28,690.35
American Medical Education Foundation Assessments	29,655.72
American Medical Association Dues	27,580.00
Due to Medical Student Loan Fund (balance of loan and interest)	30,641.90
Land, Buildings, and Equipment Reserve (contra)	148,997.69
Maternal Welfare Record Books Reserve (contra)	4,637.50
Surplus	90,221.96
Total Liabilities, Reserves, and Surplus	$531,706.92

STATEMENT OF RECEIPTS AND DISBURSEMENTS

MAY 1, 1961 — APRIL 30, 1962

RECEIPTS — GENERAL FUND

Cash Balance, May 1, 1961					$247,691.95
Assessments:	State Dues	AMA Dues	AMEF	Total	
Atlantic County	$ 5,803.32	$ 5,555.00	$ 823.34	$ 12,181.66	
Bergen County	22,905.51	17,315.00	3,274.38	43,494.89	
Burlington County	4,176.68	3,930.00	603.34	8,710.02	
Camden County	13,556.58	12,420.00	1,936.72	27,913.30	
Cape May County	1,271.66	1,182.50	181.67	2,635.83	
Cumberland County	3,359.94	2,930.00	478.38	6,768.32	
Essex County	51,671.42	44,620.00	7,381.79	103,673.21	
Gloucester County	2,467.44	2,485.00	354.20	5,306.64	
Hudson County	19,646.64	16,997.50	2,808.36	39,452.50	
Hunterdon County	1,814.16	1,750.00	260.84	3,825.00	
Mercer County	18,474.14	16,537.50	2,639.18	37,650.82	
Middlesex County	11,297.01	10,747.50	1,637.67	23,682.18	
Monmouth County	11,263.93	8,485.00	1,632.65	21,381.58	
Morris County	9,385.70	8,780.00	1,337.55	19,503.25	
Ocean County	2,753.22	2,525.00	393.39	5,671.61	
Passaic County	19,267.41	14,360.00	2,752.51	36,379.92	
Salem County	1,680.00	1,645.00	235.00	3,560.00	
Somerset County	3,365.84	3,245.00	487.50	7,098.34	
Sussex County	35.00	25.00	5.00	65.00	
Union County	19,634.80	19,100.00	2,810.10	41,544.90	
Warren County	1,400.00	1,320.00	195.00	2,915.00	
AMA Refunds		325.00		325.00	
Total Assessments	$225,230.40	$196,280.00	$ 32,228.57	$453,738.97	
Journal Advertising (net)				$ 41,063.61	
Annual Meeting Exhibits				21,381.80	
Interest Income				6,066.91	
Sale of Maternal Welfare Books				900.00	
Employees' Payroll Deductions				1,499.31	
Refunds of Budget Expenses, 1961-62				475.39	
AMA Dues Collection				1,399.87	
Membership Directory				4,136.70	
Prior Year Dues, Assessments, and Surplus Credits				1,509.07	
Interest Due to Medical Student Loan Fund				354.60	
Accounts Receivable, May 31, 1961				192.25	
Proceeds from Sale of Investments—at cost				199,018.60	
Refund of Legal Expenses				2,500.00	
Total Receipts					$734,237.08
Total					$981,929.03

DISBURSEMENTS — GENERAL FUND

Budget Accounts:

A- 1	Executive Salaries	$ 54,765.22	
A- 2	Executive Office Salaries	47,808.22	
A- 3	Executive Office Expenses	2,517.67	
A- 4	Executive Travel	1,570.13	
A- 5	House Maintenance	15,050.63	
A- 6	Treasurer	3,011.27	
A- 7	Finance and Budget Committee	42.97	
A- 8	Secretary	289.50	
A- 9	Salary Taxes	2,524.52	
A-10	Insurance	3,750.16	
C- 2	Council on Legislation	4,296.42	
C- 3	Council on Public Health	1,793.28	
C- 4	Council on Public Relations	7,875.90	
C- 5	Council on Medical Services	1,101.84	
D- 1	President and Presidential Officers	5,529.63	
D- 2	AMA Delegates	3,861.65	
D- 3	Woman's Auxiliary	7,127.52	
D- 4	Medical Education Committee	15.34	
D- 5	Conference Groups	121.70	
D- 6	Credentials, Membership, Directory, and Physicians Placement Service	860.45	
D- 7	Disaster Medical Services Committee	23.70	
D- 9	Archives and History	13.12	
D-10	Blood Bank Commission	250.00	
D-11	Medical Defense and Insurance Committee	222.60	
E- 1	Board of Trustees	2,359.13	
E- 2	Contingent	5,455.60	
E- 3	Judicial Council	564.25	
E- 4	Legal	4,188.60	
E- 6	Contribution to Medical Student Loan Fund	5,000.00	
	Total Budget Accounts		$181,991.03
	Accounts Payable		$ 18,756.95
	Purchase of U. S. Treasury Bills		288,374.30
	Journal Publication and Expenses		57,114.79
	Annual Meeting, 1961—Expenses	$ 8,712.30	
	Transfer to Med. Stu. Loan	5,599.32	14,311.62
	Transfer to Medical Student Loan Fund (Loan and Interest)		30,178.06
	AMA Dues Remitted		171,437.50
	Assessments Refunded		920.00
	American Medical Education Foundation		31,226.34
	AMA Dues Collection		1,425.37
	House Reserve Payments		3,312.31
	Extraordinary Legal Reserve		3,050.00
	Budget Expenses for 1960-61 Fiscal Year		1,209.90
	Membership Directory Expenses		11,956.99
	Total Disbursements		$815,265.15
	Cash Balance, April 30, 1962		166,663.88
	Total		$981,929.03

MEDICAL STUDENT LOAN FUND

ASSETS

Cash		$ 4,627.26
Notes Receivable—63 Loans to 49 Medical Students		58,975.35
Investments—at cost		50,445.30
Accrued Interest on Investments		170.00
Due from General Fund—Balance of Loan and Interest		30,641.90
Fund Balance, April 30, 1962		$144,859.81
(General Fund	$137,917.81)	
(Albert Barker Kump Memorial Grant	5,512.00)	
(Joseph E. Mott Memorial Grant	1,430.00 $144,859.81)	

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS

Cash Balance, May 1, 1961		$ 12,011.14
Receipts:		
Budget Appropriation from General Fund	$ 5,000.00	
Transfer from General Fund (Balance Due $30,000)	30,000.00	
Contributions	5,187.75	
Transfer from Annual Meeting Reserve	5,599.32	
Transfer of Interest from General Fund	178.06	
Proceeds from U. S. Treasury Bill Redeemed	10,000.00	
Interest on Savings Account	486.29	
Interest on Notes Receivable	135.00	
Total Receipts		56,586.42
Total		$ 68,597.56
Disbursements:		
Loans to 31 Medical Students	$ 30,000.00	
Purchase of U. S. Treasury Bills	33,970.30	
Total Disbursements		63,970.30
Cash Balance, April 30, 1962		$ 4,627.26

Received (page 441)

BOARD OF TRUSTEES

Luke A. Mulligan, M.D., Chairman, Leonia

(Reference Committee "A")

As has been the custom, the report of the Board of Trustees will highlight only the major business considered and acted upon during the year and will cover such items as are not reflected elsewhere in the reports. The majority of the Board's activities of the year have been published in THE JOURNAL. The Society's business has made increasingly heavy demands upon the time of the trustees. Ten regular and one special meetings will have been held between the annual meetings. In addition, the numerous Board committees have been called upon to meet frequently.

In the majority of instances, the Board's activities—as will be noted from the following items—have been concerned with specialized subjects which are referred to other reference committees for consideration in connection with the main subjects to be dealt with by those reference committees.

The Board of Trustees regularly has dealt with general matters brought to its attention —correspondence and resolutions from members, component societies, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; nomination of candidates to the State Board of Medical Examiners; consideration of and action on the reports and recommendations of the several standing committees and administrative councils and their special committees; cooperation with the departments of the state government, and with the allied professions of dentistry, pharmacy, nursing, law, and hospital administration.

During the year two new contacts have been established: (1) Medical-Osteopathic Liaison Committee, which promises to be valuable as a clearinghouse for discussions that will be productive of understanding and cooperation; and (2) Conference Committee with Optometrists, which has clarified certain misunderstandings between ophthalmologists and optometrists and will serve likewise as a clearinghouse for understanding and cooperation.

Two members of the Board were unable this year to attend every meeting. Dr. Jehl was called to active duty with the 114th Surgical Hospital Unit, and he has attended meetings whenever possible. Serious illness kept our First Vice-President, Dr. Ware, from the last few meetings, and it was with sincere and deep regret that the Board received Dr. Ware's decision not to advance in the presidential office. The Board was happy to learn, however, of Dr. Ware's desire to continue to serve the Society in some other capacity—where the demands "are a little less and the pace a little slower"—than than of a presidential officer.

From nominations submitted by the Board, the National Advisory Committee to the Selective Service System appointed Dr. McCall as chairman of the New Jersey Advisory Committee to Selective Service, to succeed Dr. William G. Herrman, who held the chairmanship for eleven years. The board acknowledges with deep appreciation Dr. Herrman's service to the Society, his colleagues, and his country.

In order to set forth the attitude and opinions of the Board on matters to be considered by the reference committees one or more members of the Board of Trustees have been assigned to each reference committee.

Approved (page 439)

APPLICATIONS FOR MEMBERSHIP

(Reference Committee "A")

Concerning Resolution #1—Applications for Membership—from the Hudson County Medical Society, the county society submitted an application for membership which the Committee on Credentials found to be unsatisfactory for the reason that the applicant "does not hold a degree in medicine." The only degree held by the applicant is that of doctor of osteopathy. The county executive committee requested that the State Society inform the applicant of his ineligibility for membership since it was the State Credentials Committee which found the applicant's credentials not in order. It was stated that the applicant had retained a lawyer with the intention of insti-

tuting a suit if his application for membership was rejected, and the county did not wish to be a party to a suit.

It was the opinion of the Board that it is not the duty or privilege of the State Society or the Credentials Committee to accept or reject an application. The application is received by the component society, reviewed by the State Credentials Committee, and the report of that committee is submitted to the component society. On the basis of this report the acceptance or rejection of the application is then made by the component society, as a matter of exclusive right.

On this basis the request of the Hudson County Medical Society was denied, and legal counsel was requested to draft the communication to be sent to the component society stating why the State Society cannot notify the applicant of his ineligibility for membership, and why it is the duty and responsibility of the component society to so act.

The communication sent to Hudson County as drafted by legal counsel stated:

The Medical Society of New Jersey is "composed of . . . members . . . of component societies in good standing . . ." There is no portal to membership in the corporate body of the State Society except through one of its twenty-one component medical societies. There is no provision in its corporate structure, nor any mechanism in its by-laws, for the admission of members other than by automatic admission of component society members in good standing. Likewise it has no procedure for the acceptance of members into any one of the component county societies. Each society alone has the right and the responsibility for admitting eligible medical doctors into its membership. The Credentials Committee of The Medical Society of New Jersey is a body constituted to *review* applications for membership in component societies for the purpose of insuring that deficiencies in credentials are not overlooked by the incumbents of the non-permanent membership committees of the twenty-one component societies. Deficiencies noted are acted upon by the Credentials Committee by calling the same to the attention of the appropriate county society. The Credentials Committee thus acts as a check upon the county committee and is designed to prevent the embarrassment of withdrawing privileges from one admitted to county membership through error. The Credentials Committee as such does not have the authority to deny membership but rather the responsibility for calling to the attention of a county society a deficiency which should be considered by the county society in determining whether an applicant should be admitted or not. The body having the authority to make the final decision as to membership also has the responsibility for notifying an applicant as to the decision reached in his particular case.

Any component society, as well as The Medical Society of New Jersey, is vulnerable to litigation, whether justified or not, based upon an allegation of improper denial, and the delegation by a county society to The Medical Society of New Jersey, or any other body, of the responsibility for notifying an applicant that he does not meet its standard for membership cannot, and does not, protect it from litigation originating with an unhappy, litigation-minded applicant who necessarily would proceed against the society with the authority to admit or deny.

The Hudson County Medical Society, for the reasons stated above, not only has the duty to notify the applicant of its action taken but places itself in jeopardy by failing so to act.

Adopted (page 439). Referred to Revisions Committee with Resolution #1 (page 410), which was not approved, for timely changes in the method by which members are accepted or rejected into the component society and the parent MSNJ.

CREDENTIAL FORMS

(Reference Committee "A")

Concerning Resolution # 2—Credential Forms—from the Hudson County Medical Society, the following excerpts from the minutes of the February meeting of the Board are pertinent to this resolution:

Under the Constitution and Bylaws, it is the assigned duty of the Committee on Credentials to review and act upon all applications for membership and to provide the component societies with official application forms. Completion and review of a second application, when a physician applies for advancement from associate to active membership, is a protection against acceptance of unqualified members and against possible subsequent court action.

A vital point of contention in the Falcone case was the allegation that The Medical Society of New Jersey had influenced the Middlesex County Medical Society to withdraw membership from a man to whom membership had already been granted. Admission to associate membership is not without restriction, but it is a probationary status in which he may continue for not more than two years, and then, upon application, he must be separately considered for active membership and full privileges. Unless this cleavage is maintained, it might be assumed that a physician could pass from one type of membership to another automatically. It is the unusual, the rare, and the exception that brings us to court. The second application form is a safeguard against this.

Adopted (page 439)

HSP MATERNITY BENEFITS

(Reference Committee "C")

At its December meeting the Board of Trustees received the following reply from the President of Hospital Service Plan of New Jersey to the Hudson County resolution——adopted by the 1961 House of Delegates—recommending to HSP modification of the seven day limitation for maternity service:

> Our findings lead us to the conclusion that any extension in days of hospital services for maternity cases which develop complications, would seriously threaten our financial reserves under the present rate structure. In consequence, we propose to broaden the scope of maternity services in new contracts which are currently under consideration, in which it is proposed to supplement the days presently provided in the contracts by up to 14 additional days for services necessitated by the complications of pregnancy following childbirth.

It was the action of the Board that the reply from HSP be reported to the Hudson County Medical Society and to the 1962 House of Delegates.

Approved (page 442)

JOINT MSP-HSP RIDER

(Reference Committee "C")

Last August the joint rider was reconsidered with reference to the reasons that previously the Board enumerated as the basis for withholding approval and to responses of MSP to the questions implicit in these reasons.

1) The Board had objected to the language of the proposed contracts as indicating not one rider but "two separate riders that are sold at the same time."

MSP explained that the Department of Banking and Insurance . . . "even after a protracted conference, insisted that there be two separate but related rider forms and absolutely refused to give consideration to a single form. This decision of the Department was on a strict construction of the two separate Enabling Acts regulating contract forms and statutory provisions." The Joint rider, as presented, was given tentative approval by the Department.

2) The Board requested written assurance from Hospital Service Plan that "upon official agreement to issue the joint rider, Hospital Service Plan will withdraw its application for a separate rider and will commit itself not to take steps toward the establishment of any such separate rider during the continued existence and operation of said joint rider above referred to."

A formal official agreement between MSP and HSP containing this stipulation was signed on August 15, 1961 (by Duane E. Minard, Jr., for HSP and Royal A. Schaaf, M.D., for MSP) and delivered to The Medical Society of New Jersey on August 16, 1961.

3) The Board requested "an explanation and justification for the proposed rates, inasmuch as those rates seem to indicate figures sufficient to pay for two separate rider coverages."

MSP replied that "The rates for the joint rider were developed by the actuaries for the Plans and were reviewed and approved by the consulting firm of Woodward and Fondiller. The Department of Banking and Insurance has given tentative approval to these rates pending the formal filing." MSP further pointed out "the single subscriber, who now pays $.40 to Blue Shield for the common benefits contained in Rider A, will pay an additional $.19 for these benefits in the joint rider. This additional cost is necessary due to the increased number of facilities in which these services may be obtained.

In view of the foregoing, the Board of Trustees, at its September meeting, approved the Joint MSP-HSP Rider as proposed by MSP. In accordance with the directive of the 1961 House of Delegates—in approving resolution #9 concerning a joint rider—proof forms of the joint rider as drafted were submitted to the presidents of component societies for their information.

Approved (page 442). Recommendation of reference committee adopted: That private physicians use other private physicians and their facilities whenever possible.

MEDICARE PROGRAM

(Reference Committee "C")

Twenty-six disputed claims have been reviewed and acted upon by the special committee during this year—six more than last year, but considerably fewer in comparision to the work required during the first two years of the program. Twenty-five of these claims have been settled satisfactorily, and settlement of one is still pending.

Several supplemental agreements were reviewed and, on recommendations of the committee, these contract agreements were approved by the Board of Trustees for official signature and return to Washington.

A request was received from Medical Service Administration for financial support in the amount of $5,000 "to carry us through the next year or possibly the next two years," on the basis that notice had been received from the Office of Dependent's Medical Care that it would disallow the portion of MSA salary costs. The special committee was assigned (1) to investigate alternate procedures for the future operation of the Medicare Program; and (2) to obtain information as to the itemized expenses of the MSA office in behalf of the physicians of New Jersey. On the first assignment the committee initiated its investigation by communicating with ODMC as to the reason for now disallowing a cost which had been allowed annually since the program's inception. A prompt reply was received which stated that ODMC had agreed to accept the charges for MSA's office salary costs for the contract period 1960-61, and also that they proposed to accept a like amount for the current contract period 1961-62. However, the letter emphasized that administrative costs for the operation of the Medicare Program in New Jersey are high. On the second assignment the committee obtained financial statements for the MSA office covering its operation for 1961. In view of the facts that ODMC would continue to allow the charges for MSA salary costs, and that the MSA office had a surplus at the beginning of 1962 almost equal to its operating deficit for the year 1961, it was the opinion of the committee—concurred in by the Board—that with the surplus on hand and anticipated income from the Newark Plan for 1962, plus the reimbursement for portion of salary costs from Medicare, MSA could operate on its own funds for the year 1962. This opinion was conveyed to MSA and accepted by MSA.

Concerning the negotiations of a new Medicare contract for 1962-63, ODMC has indicated the only item it has for consideration is administrative costs, and the Board of Trustees has authorized its special committee to represent the Society in the negotiations and has encouraged the officers of MSA to be equally active and completely familiar with the actual costs of administering the program, and not to leave the negotiations in the hands of the subcontractor.

Approved (page 442)

MSA BOARD OF GOVERNORS — NOMINATIONS

(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey for 1962-63 were approved by the Board of Trustees of MSNJ and are referred to the House of Delegates for action:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Approved (page 442)

NATIONAL BLUE SHIELD SENIOR CITIZENS PROGRAM

(Reference Committee "C")

Immediately following the announcement of the AMA of its endorsement of the National Blue Shield Plan's proposal for national coverage of physicians' services for those over 65 under certain income limits, the Board of Trustees directed its attention to the aspects of the proposal contingent upon the adaptation of the plan to existing conditions and circumstances in New Jersey. Conferences with MSP and MSNJ representatives were held, as well as a special meeting of both Boards of Trustees.

A special committee of the Board reviewed the National Association of Blue Shield Plan's policy letter outlining proposals for the administration of the national program, together with comments on the program contract and participating agreement offered by MSP to the National Association.

Actuarial studies conducted by MSP, based on a premium rate of $3.20 per month for a single contract which has been established by the National Association of Blue Shield Plan for all Blue Shield plans, resulted in the following conversion factors for New Jersey:

Surgery and Anesthesia	$3.00
Medical Care	$1.33
Diagnostic X-ray	$3.33
Radiation Therapy	$3.33

MSP requested to be informed of the Board's position as to the program generally and as to the above conversion factors for the Pro-

fessional Services Index, which are proposed for application under this program

The following recommendations of the special committee were approved by the Board of Trustees at its April meeting with the understanding that this matter will be referred to the 1962 House of Delegates:

1. That the Board of Trustees approve in principle the proposed National Blue Shield Senior Citizens Program.
2. That the Board, at this time, approve the Professional Services Index and the conversion factors as submitted, with the specific understanding that this approval apply to the use of the PSI and the conversion factors (Surgery and Anesthesia, $3.00; Medical Care, $1.33; Diagnostic X-ray, $3.33; and Radiation Therapy, $3.33) in connection with the proposed National Blue Shield Senior Citizens Program *exclusively.*

Approved (page 443)

MSP BOARD OF TRUSTEES—BYLAWS REVISIONS

(Reference Committee "C")

Upon learning that the MSP Board of Trustees were to consider bylaw revisions concerning offices and officers of the corporation, a joint meeting of the two Boards was requested by the MSNJ Board because it felt that the proposed revisions were of such far-reaching significance and importance that a joint meeting should be held to discuss the proposals before action was taken thereon by the Plan Board.

The revisions would:

1. Create the office of Chairman of the Board of Trustees;
2. Make the President a full-time salaried officer, who may also be the Medical Director; and
3. Retain the Executive Vice-President as a full-time salaried officer, who may also be the Medical Director.

It was stated that the reason for the proposed changes was to establish efficient means of operation—not only to strengthen the present organization but also to eliminate the necessity of phone calls and correspondence by the Executive Vice-President on matters pertaining to the corporation, in consequence of his having no power to make decisions. Therefore, in order to have better organization, it was proposed that MSP have (1) a Chairman of the Board; and (2) a President who would be a full-time salaried officer. Such an arrangement would provide better liaison not only with the Blue Shield Plans but also with Hospital Service Plan of New Jersey, which has a similar table of organization. In addition, the tremendous growth of the Plan to its current size has greatly increased the administrative details of the executive offices, and therefore necessitates a President who is available full-time and can work on an equal basis with the comparable officer of HSP.

The following amendments were unanimously agreed to by the combined Boards at the joint meeting:

1. The President shall be a Doctor of Medicine, and a member of The Medical Society of New Jersey.
2. The President shall be an ex-officio member of all committees.

It was also unanimously agreed that the President and any other officers elected need not be members of the Board of Trustees, and that it would be left to the discretion of the Plan Board as to whether the Plan President would be a Board member. It was noted that the President of HSP "may" be a member of that Plan's Board, but he has not been so elected.

Approved (page 443)

MSP OUT-PATIENT SERVICE

(Reference Committee "C")

An expression from the Board of Trustees was requested by the Plan on the following recommendation of the Plan's Internist Committee:

> That the benefits provided by Rider A be liberalized by the Medical-Surgical Plan Board of Trustees, to provide up to $10 for a physician's service in the out-patient department of a hospital when rendered in connection with the initial visit for a medical emergency, and only when rendered by a privately practicing physician who is not under contract with or employed by the hospital.

The reason for liberalizing the benefits under Rider A, rather than under the basic contract, is that the comparable HSP benefit is available only to the automotive industry, and, within a short period of time, Rider A will remain in force only for the automotive industry. The recommendation was approved by the Board.

Approved (page 443)

MSP BOARD OF TRUSTEES—NOMINATIONS

(Reference Committee "C")

Nominations for membership on the Board of Trustees of Medical-Surgical Plan for one, two, and three-year terms, were received and considered by the Board of Trustees of MSNJ. It was noted that for the first time the nominations were being submitted for terms longer than one year—to establish three year terms for Board members, to provide continuity of direction and supervision of the Plan; also, in conformity with the request of the 1961 House of Delegates, the listing of doctor-members includes "type of practice and the component society of which they are members."

The following nominations are referred to the House of Delegates for action:

Name	Type of Practice	Member of Component Society
One Year Term — 1962-63		
Charles W. Barkhorn, M.D.	Otolaryngology	Essex
Irving P. Borsher, M.D.	Internal Medicine	Essex
F. Clyde Bowers, M.D.	Internal Medicine	Morris
Robert G. Boyd		
Charles L. Cunniff, M.D.	Internal Medicine	Hudson
Andrew P. Dedick, Jr., M.D.	Radiology	Monmouth
Gustave E. Wiedenmayer		
Louis S. Wegryn, M.D. (President, MSNJ)	Surgery	Union
Two Year Term — 1962-64		
Joseph P. Donnelly, M.D.	Obstetrics-Gynecology	Hudson
Joseph I. Echikson, M.D.	Internal Medicine	Essex
Jerome G. Kaufman, M.D.	Internal Medicine	Essex
Joseph M. Keating, M.D.	Surgery	Passaic
Elton W. Lance, M.D.	Surgery	Union
Samuel J. Lloyd, M.D.	Surgery	Mercer
Jesse McCall, M.D.	Internal Medicine	Sussex
Three Year Term — 1962-65		
Duane E. Minard, Jr.		
Glennis S. Rickert, M.D.	General Practice	Morris
Royal A. Schaaf, M.D.	Surgery	Essex
Rudolph C. Schretzmann, M.D.	Obstetrics-Gynecology	Bergen
Edward W. Sprague, M.D.	Surgery	Essex
John S. Thompson		
Thomas J. White, M.D.	Internal Medicine	Hudson
David L. Yunich		

Approved (page 443). Recommendation of referer.ce comittee adopted: That physicians from South Jersey and general practitioners be included in future lists of nominees.

MAJOR MEDICAL INSURANCE

(Reference Committee "D")

It was recommended last year by the Committee on Medical Defense and Insurance that the House adopt the proposal of the National Casualty Company for major medical insurance with $500.00 deductible, and that the E. & W. Blanksteen Agency be approved as the official brokers for this program. The House referred this item to the Board of Trustees for study and action, and directed that the Board also investigate and consider negotiations with private insurance carriers to furnish these services which Blue Cross threatens to take away.

At the request of the committee chairman, Mr. Durgom submitted in writing the statements he had made before the reference committee and the House—which, in part, read:

> This is to confirm that if any group enrolled under Blue Cross purchases such a proposed overlapping Major Medical program of benefits, Blue Cross has no alternative but to serve notice of termination of that group, on the grounds of the principal of adverse selection affecting Blue Cross. This is established procedure applicable to any enrolled group under like circumstances of any degree of overlapping or duplicate coverage.

The State Dental Society have operated a major medical insurance program for several

years. Although termination of their group has been threatened, it never came about. The E. & W. Blanksteen Agency stated it was prepared to offer the same basic hospital coverage now provided by Blue Cross, if and when the major medical insurance program is adopted and Blue Cross cancels its basic coverage.

On the basis of the preceding facts, the Board approved the recommendation of the committee to the 1961 House of Delegates to establish a major medical insurance program for the membership.

Approved (page 444)

AMPAC

(Reference Committee "E")

It was the action of the Board of Trustees, at its February meeting, to officially endorse the American Medical Political Action Committee, and encourage the members of the Medical Society—voluntarily and on an individual basis—to support AMPAC, not to undertake establishment of a separate statewide committee, and to encourage solicitation of New Jersey physicians for membership in AMPAC by the national group. This action of the Board and the purposes and goals of AMPAC have been publicized in the *Membership News Letter* and THE JOURNAL.

Approved (page 445)

SENATE BILL 142

(Reference Committee "E")

Concerning resolution # 8—S-142 — from Dr. Brill, delegate from Passaic County, and the opposition to this legislation by some specialty groups and component societies, the Board approved a position of "No Action" concerning this measure only after repeated and painstaking evaluations of all aspects of the bill and after the circumstances leading up to it had been carefully weighed.

To the basic MSP contract, after a succession of inclusions of extended benefits, riders were made available to accommodate the demands of industry and labor for more fringe benefits in the form of added coverage. Among other things subscribers to Rider A, and later, Rider J are covered for specific costs incidental to diagnostic laboratory, x-ray work, and physical therapy done at the direction of the subscriber's physician.

Since 1953 directors of bioanalytical laboratories have had to be licensed by the State Board of Medical Examiners. This legislation was supported, among others, by the New Jersey Society of Pathologists. All individuals so licensed, and the laboratories which they conduct, are certified by the State as scientifically sound and dependable. Only 16 per cent of these laboratories are physician-directed. In some areas of the State, there are no physician-directed laboratories. We have been informed that at least 60 per cent of the work is now regularly being referred by practicing physicians to lay-directed laboratories. If privately operated lay-directed laboratories cannot be paid by MSP, then all or most holders of the Joint MSP-HSP Rider will wind up going to hospitals for their laboratory work—in defiance of the opposition of the House of Delegates to the encouragement of the practice of medicine by hospitals. Rather than openly take a position contrary to those physicians and medical organizations who are at variance with our opinion about this measure, we have adopted the position of "No action" on S-142 which was the same position taken on the same bill known as S-150 in 1961.

Approved (page 445)
Resolution #8 disapproved (page 445)

AMBULATORY PATIENTS

(Reference Committee "F")

The following communication was mailed to the membership last December:

> At its meeting on November 19, 1961, the Board of Trustees considered a letter which a New Jersey hospital had sent to its staff members soliciting the referral of patients to the hospital for diagnostic procedures.
>
> In this connection, the Board reviewed the following resolution, adopted by the Welfare Committee in December 1947, approved by the Board of Trustees in January 1948, and reaffirmed by the Board in April 1954:
>
> > That the sending of ambulatory private patients to hospitals for x-rays, laboratory examinations, and physical therapy treatment be discouraged where adequate facilities are available in private physicians' offices. Nothing in this resolution shall be interpreted as interfering with mass x-rays or studies, or clinic care of the indigent.
>
> The Board of Trustees agreed that even the existence and availability of Rider J (the MSP-HSP Joint Rider) does not affect the position of the Society as expressed in this resolution. Therefore, by unanimous vote, the Board reaffirmed its actions of January 1948 and of April 1954.

The Board further agreed that pressure to bring about the sending of patients to hospitals for diagnostic services should be disapproved and discouraged, and that emphasis should be placed on the fact that the treating private physician alone, on the basis of his professional judgment, should decide where to send his patients for such services.

Accepted (page 448)

MEDICAL-LEGAL TESTIMONY

(Reference Committee "F")

On July 27, 1961, the Supreme Court of New Jersey adopted Rule 4:25 A—Impartial Medical Examinations and Expert Testimony—to be effected with the opening of the new term of court in September. The Rule is applicable to actions instituted in the Superior and County Courts in Essex, Morris, Union, and Warren Counties, to recover damages for personal injuries or wrongful death when the nature, extent, or cause of injuries or the cause of death are in dispute. For the purpose of this Rule, the Administrative Director of the Courts will maintain a panel of impartial medical experts. The specialties to be represented on the panel and the number of experts in each specialty shall be determined jointly by The Medical Society of New Jersey and an Advisory Committee appointed by the Supreme Court. The experts to serve on the panel in the several specialties shall be designated by The Medical Society of New Jersey. This was announced as a three-year pilot experiment in the four counties which compose the first district within The Medical Society of New Jersey and a list of eighteen specialties were submitted by the Court's committee.

With the cooperation of the presidents of the four component societies concerned, the names of at least three qualified nominees, as far as possible, in each of the eighteen categories specified, were appointed at state level. The appointees were selected from physician-members who, by the nature of their practice (such as compensation work) are not frequently appearing in court.

In December, 1961, with the sending of lists of panels of impartial medical witnesses to the Administrator of the Courts, the efforts of the Board in this area were realized after thirteen years of study and conference.

Approved (page 448)

Supplemental Reports

RVI POSTAL MAIL POLL

(Reference Committee "F")

	Questionnaire To Active Members	Total Returns	Vote on Proposed RVI for N. J.		
County	4-21-62	5-11-62	Approve Adoption	Oppose Adoption	No Vote
Atlantic	166	63	46	16	1
Bergen	649	309	140	166	3
Burlington	115	53	36	16	1
Camden	357	171	69	102	
Cape May	39	22	13	9	
Cumberland	95	42	34	7	1
Essex	1,509	613	346	263	4
Gloucester	67	30	11	18	1
Hudson	630	225	85	139	1
Hunterdon	56	28	9	19	
Mercer	416	174	107	67	
Middlesex	315	142	67	74	1
Monmouth	318	186	76	108	2
Morris	269	140	84	54	2
Ocean	76	36	16	20	
Passaic	572	242	145	97	
Salem	47	34	27	7	
Somerset	98	49	40	8	1
Sussex	42	22	12	9	1
Union	578	251	118	131	2
Warren	39	25	14	11	
	(100%)	(44.3%)	(23.2%)	(20.8%)	(.3%)
TOTAL	6,453	2,857	1,495	1,341	21
			(100%)	(52.3%)	(47%) (.7%)

Tabled (page 448)

HR 4222

(Reference Committee "E")

The Board of Trustees, on the evening of May 11, 1962, spent a major portion of its meeting in discussion of and evaluation of the public relations situation confronting the Society in consequence of recent developments concerning H.R. 4222.

It was the consensus of the Board that in view of the entire situation any declaration from the House of Delegates should advisedly reaffirm the Society's official position concerning H.R. 4222 and all similar legislation as contained in earlier official pronouncements and published in the January 1962 *Periodic News Letter*.

The Board further agreed to suggest to the House the desirability of adding a statement similar to the following:

The Medical Society of New Jersey has not been, and will not be, involved in the purely conjectural situation, indulged by certain physicians as individuals, as to what would or should be done by physicians with reference to this legislation should it be passed.

The Medical Society of New Jersey considers it sufficient to point out that just as, since 1766, its members have supplied the best possible medical care to the people of New Jersey, so they will continue to do. The Society adds this assurance—in reaffirmation of its frequently declared policy—"No one in New Jersey will be denied necessary medical care because of inability to pay."

Moreover, the Board suggests that the House consider the desirability of authorizing the Board of Trustees to appoint an official committee to meet with the Governor and/or other duly constituted authorities to clarify the Society's policies and position.

Report of reference committee amended to read, as follows:

Your committee recommends conformity with the suggestions contained in the supplemental report of the Board of Trustees that the official position of The Medical Society of New Jersey concerning the King-Anderson Bill, HR 4222—or any similar legislation—as submitted by President Buchanan to the House Ways and Means Committee, under date of July 6, 1961, be at this time reaffirmed. It follows:

The Medical Society of New Jersey—in common not only with other members of the medical profession but with all who are dedicated to the preservation of a sound character in our people and in our nation and to the maintenance of a sound and well-balanced national economy—is "for":

1. The retention by the individual citizen—and of that citizen's family—of the responsibility and the right for selecting, arranging, and paying for his own necessary health care.

2. The limitation of tax burdens upon the individual citizen and his family so as to leave to them the financial means of meeting this responsibility.

3. The development and widespread utilization of adequate and economical private voluntary health insurance coverages as the best means of enabling such individual citizen and his family to meet this responsibility.

4. The intervention of government to assist only those citizens who need health care and are themselves demonstrably incapable of meeting the costs for it.

5. The maintenance of a minimum of federal governmental intervention and control. We hold that the assignment of responsibility for financing necessary health care should be in the following order: the individual citizen; the family; local voluntary agencies; local, county, state, and federal government . . . each to take over only when the prior agent of responsibility cannot meet the need. Because of this point of view we support the principle of the Kerr-Mills law as essentially preferable to the principle of the King-Anderson Bill, HR 4222, and all like legislation.

In consequence of what it is "for," The Medical Society of New Jersey is necessarily "against":

1. Any policy or program that would relieve or wrest from the individual and the family the right and responsibility to be independent, self-sustaining, self-reliant, and free.

2. Any policy or program that would so multiply burdensome taxes upon the individual citizen and his family as to deprive them of the financial means to retain and exercise those four fundamental rights and responsibilities.

3. Any policy or program that would encourage government, at any level, to eliminate or supplant voluntary free enterprise systems of insurance coverage, or of any other fundamental business or service operation.

4. Any policy or program that would enlarge for government, at any level, entrance into and influence over the lives, rights, and duties of individual citizens . . . in short, any policy or program that would give to government the control and direction of the lives of citizens instead of reserving to citizens the control and direction of their government.

Your committee further recommends that The Medical Society of New Jersey officially records its recognition of the right of its members to hold and express views and opinions relating to the conditions under which they will practice medicine for the greatest benefit of their patients, but as an organization The Medical Society of New Jersey is not involved in, or responsible for, their individual points of view.

The Medical Society of New Jersey considers it sufficient to point out that just as, since 1766, its members have supplied the best possible medical care to the people of New Jersey, so they will continue to do. The Society adds this assurance—in reaffirmation of its frequently declared policy—"No one in New Jersey will be denied necessary medical care because of inability to pay."

Further, the reference committee recommends that The Medical Society affirm that, as loyal citizens of this nation, its members will continue to provide the best possible medical care within the framework of the laws of the State of New Jersey and of the nation.

Your reference committee also recommends that the House authorize the Board of Trustees to appoint an official committee to meet with the Governor of New Jersey and/or other duly constituted authorities, to clarify the Society's policies and position.

It is the opinion of your committee that The Medical Society of New Jersey should reaffirm its conviction that the continuing expansion, perfecting and implementation of prepaid voluntary insurance plans, and the implementation of existing national legislation as exemplified by the Kerr-Mills Law, be supported and would be in the best interest of making such care as we desire available to all the citizens. Further, that it reaffirms its continuing opposition to such legislation as exemplified by HR 4222, the King-Anderson Bill, which it is convinced would lead to the deterioration of the quality of medical care by the additional imposition of federal governmental controls.

Adopted as amended **(page 446)**

EXECUTIVE OFFICER

Richard I. Nevin, Trenton

(Reference Committee "A")

With the end of winter and the advent of spring, while the fancy of young men the world over lightly turns to thoughts of love, and taxpayers the nation over grimly prepare their income tax returns, and farmers and gardeners recall the harvest past and dream of the harvest to come, we of The Medical Society of New Jersey present accountings for the administrative year ending and indulge our dreams and schemes for the year that is about to begin. There is a natural timeliness in all of this that the calendar does not sustain. Spring marks the true beginning of a new year in nature. It is the time of dreaming and of sowing, when we cleanse our fields and our minds of what has been, and plan the work for that which is to be.

The year now closing has been chronicled and analyzed in general and in detail in all the various reports submitted for the attention of this House. As Executive Officer, I can testify that it has been a year of intense and, in great part, of efficient activity. We have, with good effect, sustained and maintained our contacts and services with and for our members—in membership, placement, insurance, legislation, and liaison—with the AMA, specialty societies, our Woman's Auxiliary, other professions, governmental and private agencies, and the public. We have kept in close contact with component societies and have, by correspondence, phone calls, and visits, tried to keep them well-informed of our organizational activities and to afford them and their members all available information and help.

The work of the year has been a splendidly cooperative venture, and as one so situated as to be able to appreciate all that has been undertaken and accomplished, I can say that the Society owes a debt of gratitude not only to the officers and Board members but to all of our councils, committees, and staff who have given of themselves for the good of our members and of the public at large.

The world of Medicine is an expanding one. It is one of increasing interest to all types of people, but inviting especially the attention and exploration of hopeful claim-stakers and would-be conquerors, impelled by motives that range from selfless altruism to the rankest self-interest. It is a world at present distressfully restless and uneasy by virtue of a movement to change the old order simply because it is old, and to embrace a new order on the assumption that because it is new it is therefore better.

It is the task of those who would well serve the true good of the world of Medicine to distinguish and preserve that of the old order which is sound and good, and at the same time

to select and adopt those innovations and changes which are demonstrably consonant with the true good of Medicine and mankind and conducive to the increasing dignity and perfection of individual men and women and the society of which they are part.

The Medical Society of New Jersey is striving to do its part in this new and expanding world of Medicine. Our efforts in this regard are reflected to some measure in practically every undertaking in which as a society we engage. We cannot expect to persevere in the pursuit of our disciplined objectives without criticism or disparagement from those whose goals are incompatible with ours. This should not deter or discourage us. Our first obligation is to be sure that what we stand for is right and sound and good. Our second follows from that—to be unflaggingly zealous in working for the assurred attainment of that verified, worthy goal.

So physicians have lived and served as members of the profession of medicine, in the sphere of patient-care. So now they must live and serve as citizens and members of American society, working for the health and survival of our free society and our country. Because of the changing world of Medicine one cannot now do his full duty as a physician unless he also does his full duty as a citizen.

In the year now ending, in that work and in that spirit, we of The Medical Society of New Jersey have been engaged. That work and that spirit have involved and sustained me, as Executive Officer, at my desk and in 194 meetings, conferences, conventions, or hearings; in 14 speaking engagements, in 12 visits to county societies; in 5 meetings with county auxiliaries; and in 6 meetings out of state. In common with all your other officers and workers, I regret that I could not do more.

In the year upon which now we enter, the prospect is that the pressures on us all will increase and that the challenges to our purposes and dreams will multiply. We must and shall grow to meet them. It is adversity which engenders greatness. We cannot run the risk of succeeding unless we run the risk of failing.

In this spirit of faith and hope and truth—buttressed courage, we bring the old year to a close and turn to face the new. It is not time that counts, but what we as men do with it. Let us use it well, to prove ourselves and to improve our world.

Approved (page 439)

JUDICIAL COUNCIL

Emanuel M. Satulsky, M.D., Chairman, Elizabeth

(Reference Committee "A")

The Judicial Council, which met seven times during the year, presents the following resume of its operations and those of county judicial committees for the year now ending (as of April 1, 1962):

BY THE JUDICIAL COUNCIL

Official communications acted upon	21
Appeal hearings granted	6
Disposed of	5
Pending	1
Formal Opinions Rendered	13

Ethical acceptability of:

(a) patient's right to records of previous treatment by a physician

(b) voluntary professional association of members of MSNJ with other fully licensed physicians and surgeons of the State of New Jersey

(c) a member's assuming full staff appointment in a hospital, whether or not that hospital is approved by the Joint Commission on Accreditation of Hospitals

(d) a member's sending to attorneys formal announcement of his specialization in medical jurisprudence

(e) a permanent association between physicians on a straight 50-50 partnership, with equal shares of incomes and expenses

(f) the method of purchasing whatever equity there is in the good-will of the practice of a physician by paying a certain per cent of the gross income from the practice over a period of time

(g) a physician's prescribing for members of his own family

(h) a physician's selling his x-ray equipment to a company which would bill patients for x-rays taken and pay the physician a salary for reading those x-rays

(i) making use of a tape recorder in hearings before a county judicial committee

(j) a hospital's sending to physician-staff-members a letter announcing that it is "accepting all private patients" for diagnostic procedure and listing the names of two physicians who will do this work (referral from the Board of Trustees)

(k) a physician's serving as consultant to a manufacturer under certain specified conditions

(l) publicity involving doctors and hospitals presented as news items in the local press, describing a new surgical procedure and identifying the surgeon and hospital concerned

(m) a physician's utilizing a magazine rack that will display magazines, supplied as a cooperating service by a hearing aid company and a local hearing aid dealer

(N.B. For the information of the membership, these 13 opinions are presented in full as an appendix to this report.)

BY COUNTY JUDICIAL COMMITTEES

Complaints reported as disposed of	104
Alleging:	
excessive fees	58
unsatisfactory professional services	28
refusal to fill out forms	3
billing for services not rendered	2
failure to answer emergency call	3
solicitation of patients	1
refusal to make house call	1
unethical conduct	6
refusal to render treatment	1
refusal to issue payment receipt	1

JUDICIAL MECHANISM

The relationship of the Judicial Council and its judicial mechanism to the membership of the Society is summarized in a declaration made at the April 1961 meeting of the Council, in response to a communication from a member who declared it as his opinion that the judicial mechanism was merely advisory. In this connection the Council declared:

"The Judicial Council at state level and the judicial committees of the component societies are definitely not merely advisory in character. They hold power, under the constitution and bylaws of the MSNJ, to receive and adjudicate complaints from any source concerning the professional conduct or ethical deportment of members of MSNJ. Their decisions are binding upon all members of MSNJ, and the judicial committee of each component society in the enforcement of its findings, duly arrived

at, has the power 'to censure, suspend, or expel any member of its society for just cause.' All decisions of the Judicial Council and of the judicial committees are binding upon all members of MSNJ. They are not offered to members merely as advice—and no member is free to decide whether or not he shall conform to them. A member has the right of appeal from the findings arrived at by a judicial committee to the Judicial Council of MSNJ and from the Judicial Council of MSNJ to the AMA Judicial Council. But this right of appeal in no wise implies any modification or limitation of the power of the judicial mechanism over the member-physician."

The Chairman thanks the members of the Judicial Council for their consistently efficient attention to and conduct of the business of the Council, and takes this means of expressing to members of the judicial committees of component societies the appreciation of the Judicial Council for their fine cooperation throughout the year.

RIGHTS OF A PATIENT TO RECORDS OF PREVIOUS TREATMENT BY A PHYSICIAN

(Opinion Adopted April 23, 1961)

The president of a county medical society sought the advice and opinion from the Council concerning the failure of one of their members to comply with the request of a former patient and her treating physician for information necessary for the care of the patient, who has moved out of state.

Inasmuch as this request comes authentically from the treating physician under whose care the patient now is, the Judicial Council regarded compliance with this as a matter of professional cooperation and conduct. It was the opinion of the Judicial Council, therefore, that the physician should be made to understand unequivocally that in justice to himself as a reputable physician, to his former patient whose welfare is involved, and to the profession, he should comply with the request without delay.

The Judicial Council took this occasion to remind the president of the county medical society that the decisions of county judicial committees are binding on all members of the MSNJ, and the judicial committee of each component society in the enforcement of its findings duly arrived at has the power "to censure, suspend, or expel any member of its society for just cause." These decisions are not offered to members merely as advice or suggestions and no member is free to decide whether or not he will conform to them.

VOLUNTARY PROFESSIONAL ASSOCIATION OF MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY WITH OTHER FULLY LICENSED PHYSICIANS AND SURGEONS OF THE STATE OF NEW JERSEY

(Opinion Adopted July 12, 1961)

Whereas, recent action by the Joint Commission on Accreditation of Hospitals indicates that the presence on hospital medical staffs of doctors of osteopathy having full licenses as physicians and surgeons will not jeopardize *per se* accreditation of such hospitals; and

Whereas, in a recent opinion ordering one of the component societies of The Medical Society of New Jersey to accept an osteopathic physician as an active member, the Supreme Court of New Jersey declared that any graduate of an osteopathic school approved by the New Jersey State Board of Medical Examiners has received "a full course in Medicine"; and

Whereas, the Judicial Council of The Medical Society of New Jersey, in conformity with the action of the House of Delegates of the American Medical Association and in support of the code of ethics of the American Medical Association, has heretofore ruled that any voluntary professional association between doctors of medicine and doctors of osteopathy is unethical; and

Whereas, the House of Delegates of the American Medical Association at its 1961 Annual Meeting ruled that policy regarding relationships of doctors of medicine with doctors of osteopathy "should now be applied individually at state level according to the facts as they exist"; now therefore be it

Resolved, that—previous opinions to the contrary notwithstanding—the Judicial Council of The Medical Society of New Jersey now declares that hereafter in New Jersey it shall not be unethical for members of The Medical Society of New Jersey to enter into voluntary professional association with any person holding a full license as a physician and surgeon granted by the State Board of Medical Examiners of New Jersey who adheres to the same scientific principles embraced by the members of The Medical Society of New Jersey.

A MEMBER-PHYSICIAN'S ASSUMING FULL STAFF APPOINTMENT, INCLUDING CHIEF OF SERVICE, IN AN OSTEOPATHIC HOSPITAL WHETHER OR NOT THAT HOSPITAL IS APPROVED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

(Opinion Adopted September 24, 1961)

The Council directed that it did not—and has never regarded it necessary to—issue an opinion concerning the ethical propriety of a member of The Medical Society of New Jersey's associating himself with a non-accredited hospital or joining the staff of any hospital. The recent opinion concerning the ethicality of voluntary professional association of physician-members with "other fully licensed physicians and surgeons of the State of New Jersey" has application to the individual or personal professional relations of an individual member with all other fully licensed physicians. The physician-member is free (but not obliged) "to enter into voluntary professional association with any person holding a full license as a physician and surgeon granted by the State Board of Medical Examiners of New Jersey who adheres to the same scientific principles embraced by the members of The Medical Society of New Jersey." Whether or not a member chooses to be associated with a non-accredited hospital is up to him. The Judicial Council—and, indeed, the Medical Society—makes no distinction in this regard.

A MEMBER-PHYSICIAN'S SENDING TO ATTORNEYS FORMAL ANNOUNCEMENT OF HIS SPECIALIZATION IN MEDICAL JURISPRUDENCE

(Opinion Adopted September 24, 1961)

Because this procedure is one that can only be determined by local considerations, the Council directed that the matter be referred to the county medical society of which the physician is a member, in accordance with the following dictum from the Judicial Council of the American Medical Association:

> . . . The particular use to be made of any ethical advertising medium and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine, what transcends advertising and becomes solicitation are questions of fact. The application of this principle is to be made locally . . . (JAMA, March 30, 1957)

A PERMANENT ASSOCIATION BETWEEN PHYSICIAN-MEMBERS, ON A STRAIGHT 50-50 PARTNERSHIP WITH EQUAL SHARES OF INCOME AND EXPENSES

(Opinion Adopted October 22, 1961)

The Council unanimously agreed that there was nothing contrary to ethical principles involved in this strictly business arrangement.

THE METHOD OF PURCHASING WHATEVER EQUITY THERE IS IN THE GOOD WILL OF THE PRACTICE OF A PHYSICIAN BY PAYING A CERTAIN PER CENT OF THE GROSS INCOME FROM THE PRACTICE OVER A PERIOD OF TIME

(Opinion Adopted October 22, 1961)

The Council unanimously agreed with the opinion of the county medical society that such action would not be understood as fee-splitting, but was merely a business agreement.

A PHYSICIAN'S PRESCRIBING FOR MEMBERS OF HIS OWN FAMILY

(Opinion Adopted October 22, 1961)

The Council unanimously agreed that there exists no specific ethical or professional prohibition against a physician's treating members of his own family. However, it also agreed that the practice is not usual, since most physicians seem to prefer to refer members of their families to their professional colleagues.

In making this declaration the Council was cognizant that a similar request made to the Judicial Council of the AMA was answered as follows: The Principles of Medical Ethics provide:

> "As a general rule, a physician should not attempt to treat members of his family or himself." This provision is still accepted by the medical profession.

The Council calls attention to the fact that the foregoing declaration does not specifically prohibit such action on the part of a physician but merely indicates that—"as a general rule" (by implications admitting of exceptions)—a physician "should not" (not "must not") attempt to treat members of his family or himself. In consequence it concluded as set forth above that "there exists no specific ethical or professional prohibition."

It was the Council's unanimous opinion that all requests for interpretation of, and/or questions concerning standards of, medical ethics or professional conduct in New Jersey are proper to the jurisdiction of the Judicial Council of The Medical Society of New Jersey, and as such should not be accepted for answer by any other agency.

A PHYSICIAN'S SELLING HIS X-RAY EQUIPMENT TO A COMPANY WHICH WOULD BILL PATIENTS FOR X-RAYS TAKEN AND PAY THE PHYSICIAN A SALARY FOR READING THOSE X-RAYS

(Opinion Adopted December 10, 1961)

Insofar as it understands the proposal the Council declared that nothing in it would be fundamentally in opposition to the Principles of Medical Ethics. In this connection it referred to an earlier opinion (#4, July 17, 1955).

The Council further declared that questions of legality are not proper to its jurisdiction and, therefore, opinions concerning the legality of this procedure should be referred to the member-physician's own legal counsel.

OFFICIAL ACCEPTABILITY OF MAKING USE OF A TAPE RECORDER IN HEARINGS BEFORE A COUNTY JUDICIAL COMMITTEE

(Opinion Adopted December 10, 1961)

The Council reaffirmed its desire always to maintain informality in the conduct of hearings, and to utilize as little as possible any procedures which would tend to give the judicial mechanism legalistic overtones.

In this spirit, it was the Council's opinion that the introduction of a tape recorder during a hearing would destroy the purpose and informal character of the mechanism, and would be undesirable.

The Council, therefore, recommended that, for the hearing itself, county judicial committees refrain from using a tape recorder.

A HOSPITAL'S SENDING TO PHYSICIAN-STAFF-MEMBERS A LETTER ANNOUNCING THAT IT IS "ACCEPTING ALL PRIVATE PATIENTS" FOR DIAGNOSTIC PROCEDURE AND LISTING THE NAMES OF TWO PHYSICIANS WHO WILL DO THIS WORK

(Referral from Board of Trustees)

(Opinion Adopted January 28, 1962)

The Judicial Council discussed this communication at length, and unanimously agreed that:

1) The letter obviously was an official communication from the hospital to the members of its staff; and the hospital, as such, is not subject to the Principles of Medical Ethics of The Medical Society of New Jersey.

2) The letter obviously was signed by the Executive Director in his official capacity as a hospital administrator and not in his own person. However, even if he were acting in his own person, inasmuch as he is not a member of MSNJ the Council would have no jurisdiction over him in the matter of ethics.

3) If the letter involved the direct solicitation of patients in the unethical sense which the Principles of Medical Ethics have been interpreted as prohibiting, the communication would have been addressed to the general public either by means of an announcement in the press or by some other media of general information. The fact that it was not would seem to be an indication that the hospital was mindful of this prohibition. As issued the letter was literally an official announcement to staff members of additional facilities and services available to them at the hospital in the care of their patients.

4) There was question as to whether or not the doctors involved permitted the use of their names in this communication, or offered their names with full knowledge and consent.

5) There was question, also—which only investigation could evaluate—as to whether or not the utilization of these two names exclusive of all the other physicians in the area practicing the same specialty was a form of exploitation or glorification of them, which is subject to ethical interpretation.

> Self-laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved. (Principles of Medical Ethics, 1955 edition, Chapter I, Section 4)

If this aspect of the communication is to be investigated and determined, the matter would be proper to the responsibility and jurisdiction of the component medical society in which the doctors hold membership.

The Council therefore directed that this matter be referred to the judicial committee of the local county medical society for such action as it may wish to take, together with a copy of an earlier opinion rendered by the Council in a similar situation (#12, September 28, 1958).

A PHYSICIAN'S SERVING AS CONSULTANT TO A MANUFACTURER UNDER CERTAIN SPECIFIED CONDITIONS

(Opinion Adopted January 28, 1962)

The Council expressed commendation and appreciation to the member-physician involved for his good faith and good will in submitting this request for its consideration and advice. However, the Council was compelled to point out the following section of the Principles of Medical Ethics which, in its opening sentence, seemed to preclude the possibility of the physician's serving in the capacity specified:

> Section 7—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

The Council also called attention to the following relevant excerpt:

> A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual by whatever name called or however organized, under terms or conditions which permit exploitation of the services of the physician for financial profit to the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people. (Principles of Medical Ethics, 1955 edition, Chapter VII, Section 5)

PUBLICITY INVOLVING DOCTORS AND HOSPITALS PRESENTED AS NEWS ITEMS IN THE LOCAL PRESS, DESCRIBING A NEW SURGICAL PROCEDURE, AND IDENTIFYING THE SURGEON AND THE HOSPITAL CONCERNED

(Opinion Adopted January 28, 1962)

In considering this request, the Council called attention to the Principles of Medical Ethics, 1955 edition, Chapter I, Section 5, "Advertising":

> Solicitation of patients, directly or indirectly, by a physician, by groups of physicians or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is, concerned. Self-laudations defy the traditions and lower the moral standards of the medical profession; they are an infraction of good taste and are disapproved.
>
> The most worthy and effective advertisement possible, even for a young physician especially among his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of simple professional cards is approved in some localities but is disapproved in others. Disregard of local customs and offenses against recognized ideals are unethical.

In light of this opinion, the Council directed that the matter be referred to the judicial Committee of the local county medical society, under whose jurisdiction this item comes, for such action as it may wish to take.

THE ETHICAL ACCEPTABILITY OF A PHYSICIAN'S UTILIZING A MAGAZINE RACK IN HIS OFFICE THAT WILL DISPLAY MAGAZINES, SUPPLIED AS A COOPERATING SERVICE BY A HEARING AID COMPANY AND A LOCAL HEARING AID DEALER

(Opinion Adopted March 25, 1962)

For an official declaration in this matter, the Council agreed that the request must be referred to the component medical society in which the physician holds membership, in accordance with the AMA Principles of Medical Ethics (Section 5, 1955 edition):

> The particular use to be made of any ethical advertising medium and the extent of that use are, however, matters to be determined according to local ideals. What constitutes an excess, what is not in keeping with the ideals of medicine, what transcends advertising and becomes solicitation are questions of fact. The application of this principle is to be made locally. (JAMA, March 30, 1957)

The Council observed, however, that the utilization by a physician in his waiting room of a single advertisement for an agency seems to indicate tacit exclusive approval of that agency or its product. The Council urged that this aspect be kept in mind, in the interest of professional propriety and good taste.

Adopted (page 440)

ANNUAL MEETING

Jerome G. Kaufman, M.D., Chairman, Maplewood

(Reference Committee "H")

A particularly interesting and outstanding program has been arranged for the 1962 annual meeting. The fine cooperation between the section officers and chairmen of the Committees on Scientific Exhibits and Scientific Program has resulted in an exceptional meeting covering a wide variety of subjects which should appeal to all branches of the medical profession.

EXHIBITS

The combined exhibits—educational, scientific, and technical—total 106 this year. As in the past, the scientific exhibits will present results from the latest significant investigations; and the educational exhibits will present the up-to-date developments in programs and projects of the Society's committees and cooperating agencies.

A change in room assignments this year necessitated placement of the scientific exhibits in another location in the headquarters hotel. Inasmuch as this new location would not accommodate educational as well as scientific exhibits, the educational exhibits will be found among the technical exhibits.

Notwithstanding the fact that there will be a few less commercial exhibits this year, late requests for space were received from several new companies who will supplement the 1963 list of prospective exhibitors.

Costs entailed in the successful presentation of the annual meeting are met by the sale of space in the technical exhibits, and all members are urged to visit the displays and discuss the products presented.

In accordance with the recommendation of the 1959 House of Delegates, the exhibits will again open on Sunday—May 13, 1962—to afford the delegates an opportunity to visit the exhibits "since many leave on Monday after the House has adjourned." Inasmuch as it was felt that this practice has proved worthwhile, the early opening of exhibits will be continued.

MOTION PICTURE THEATER

Through the cooperation of Smith Kline & French Laboratories, the motion picture theater program, related to the subjects covered by the scientific program, has been arranged. Appreciation is again expressed to the company for this valuable addition to our annual meeting program.

ATTENDANCE

In a further effort to increase attendance at the annual meeting, copies of the advance program were sent to presidents of medical staffs of all New Jersey, New York City, and Philadelphia hospitals, inviting staff members to attend the annual meeting. Copies were also sent to the Medical Societies of New York, Pennsylvania, Connecticut, Maryland, and Delaware, requesting that the scientific sessions be publicized in their Journals, together with an invitation to their members to attend the meeting, specifically noting that there is no registration fee for out-of-state physician-guests.

An item soliciting questions from the membership for presentation to and discussion by program panel members was included in the advance program (February *Membership News Letter*), and in the convention issue of THE JOURNAL (April).

BICENTENNIAL CELEBRATION

Referred to the committee by the Board of Trustees was an item concerning the 200th anniversary of The Medical Society of New Jersey—1966. Coincident with the 200th anniversary of the Medical Society, six component societies — Cumberland, Essex, Middlesex, Monmouth, Morris, and Somerset—will celebrate their 150th anniversaries. Assistance was requested from the State Society, particularly access to the Society's archives and for financial support for clerical and research help. It was the action of the committee—subsequently approved by the Board of Trustees—that an annual appropriation from the annual meeting reserve account be made available to the Society's Historian-Archivist, Dr. Rogers, for the next four years; and that in recognition of the efforts of component societies which want to preserve for posterity historical knowledge of medical efforts in their

counties, that State Society historical records be made available to local representatives visiting the headquarters building for purposes of historical research culminating in the meeting of 1966.

MEETING DATES

Because of the increasingly heavy convention schedule each spring in Atlantic City, it has been found advisable to set meeting dates at least four years in advance in order to assure desirable dates and hotel accommodations. The House of Delegates has already approved the following convention dates which have been confirmed with Haddon Hall:

197th meeting—Saturday-Wednesday, May 11-15, 1963
198th meeting—Saturday-Wednesday, May 16-20, 1964
199th meeting—Saturday-Wednesday, May 15-19, 1965

RECOMMENDATION

That the 200th annual meeting be held at Haddon Hall, Atlantic City—Saturday-Wednesday, May 14-18, 1966.

Approved (page 450)

*SCIENTIFIC EXHIBITS

Milton Ackerman, M.D., Chairman, Atlantic City

(Reference Committee "H")

The committee took the following actions during the year 1961-62:

1) Reviewed the exhibit plan, exhibitors, and general conduct of the scientific exhibit of the 1961 annual meeting.

2) Discussed the possible effects related to numbers of exhibitors, exhibit lay-out, accessibility, etc., necessitated by the change in the space and room assigned for the scientific exhibit for the 1962 annual meeting.

3) Reviewed the applications for the scientific exhibit and assigned space to accepted applicants. Insofar as possible, exhibits were grouped within the exhibit lay-out according to subject matter.

4) Selected a group of suitable films and established a schedule for the showing of these films in the Motion Picture Theatre, again to be presented through the cooperation of Smith Kline & French Laboratories, for which the committee is greatly appreciative.

5) Organized an Awards Committee for the judging of exhibits.

6) Established some minor revisions in the award plaques, necessitated by the increase in numbers of sponsors for the individual exhibits.

Approved (page 450)

*SCIENTIFIC PROGRAM

Edward E. Seidmon, M.D., Chairman, Plainfield

(Reference Committee "H")

Plans for the 1962 annual meeting scientific program were initiated at a meeting with the section officers in June of 1961. In late September of 1961, a second meeting of the section officers was held at which time the scientific program was outlined. As previously agreed, joint programs were developed, thus reducing to thirteen the number of scientific sessions to be presented by the twenty sections.

The annual meeting is a "medical forum," and all sections have heeded our urging that their programs be made attractive to the general membership. We believe this year that some phase of the scientific program will appeal to each and every member. The section officers are to be congratulated for the selection of their topics and their speakers.

The outstanding scientific program which our sections have prepared for presentation at the 1962 annual meeting deserves the recognition and support of the membership. All members are urged to attend the scientific session of their choice.

Approved (page 450)

*Subcommittees of the Annual Meeting Committee.

CREDENTIALS

Marcus H. Greifinger, M.D., Chairman, Newark

(Reference Committee "A")

As of April 1, 1962 the Committee on Credentials had met five times to consider and act upon the credentials of all candidates for associate or active membership. To assist in the uniform disposition of matters before it, in the course of the year the Committee adopted a number of critical and procedural standards.

Below is listed a statistical breakdown of the applications for membership received during the period June 1, 1961 to April 6, 1962:

	Assoc.	Advancement to Active	Active	Total
Received	249	212	52	513
Reviewed & found:				
Satisfactory	229	196	50	475
Unsatisfactory*	4	0	0	4
Pending	16	16	2	34

*Did not hold degrees in medicine.

At the recommendation of the Executive Committee—approved by the Board of Trustees on November 19, 1961—the committee agreed to hold regular meetings to expedite its business and protect the Society legally. It felt that actions of the committee might be technically assailable in the courts, if those actions were not all taken at regular, plenary sessions of the committee and recorded in the official minutes thereof.

On a number of occasions the committee has found it necessary to affirm that its only constituted authority is to review and evaluate the credentials of applicants for membership in component societies. To clarify this position, the Committee has adopted a new report form, issued to component societies, which in substance states that the committee has reviewed the credentials of the applicant and has found them satisfactory or unsatisfactory on the basis of the Constitution and Bylaws of The Medical Society of New Jersey. The acceptance or rejection of the application is to be made by the component society.

The committee established a standard procedure for reviewing the credentials of all applicants for membership. When application forms are received at the Executive Offices they are checked by the staff of the Membership Department to see that they are in good order and that all the required information has been supplied. All application forms that are deficient in any respect are returned to the component society with the special instruction that necessary corrections are to be made by the applicant. The application data is then verified against *The Register of the State Board of Medical Examiners.* The photograph affixed to each application is also compared with the picture on file with the State Board. All applications are classified by Judicial Districts and sent to the committee member of the proper Judicial District for detailed review. The findings of the district representatives are then presented in summary form for committee action at its next regular meeting.

It was apparent to the committee in performing its routine functions that some component societies are not processing their membership applications in accordance with procedures originally established and recommended for uniform use by all component societies. When applications for membership are received by component societies, it is the responsibility of a designated committee (usually Board of Censors or Executive Committee) to review, investigate, and pass upon all applications as submitted. Applications are not to be forwarded to this committee until after they have been considered by the proper committee of the component society. This committee then reviews the credentials of all applicants, reporting its findings to the component societies. Only after the findings of the committee have been reported may the applications be submitted to the membership of the component societies for official action.

During the year the committee policy of requiring that a second application and photograph be filed when applications for advancement from associate to active membership is being made has been questioned. The committee is convinced that the utilization of separate application procedures is necessary to demonstrate for the record, in case of subsequent legal action, that admission to associate membership confers only a probationary and restricted connection with the Society upon the applicant and does not lead automatically to

admission to full membership. By this means the committee also hopes to bring to light any discrepancy in credentials which might have a controlling influence on the acceptance or rejection of an applicant by a component society. It is, therefore, the committee's opinion that the standards for filing a second application, for advancement from associate to active membership must be the same as those imposed upon candidates for associate membership.

The Committee desires to express its appreciation to the officers of component societies for their cooperation. Throughout the year the committee has been proceeding to establish a dependable mechanism. It has gratefully received suggestions and invites further suggestions from the county societies.

Below are listed the procedural decisions taken by the Committee during the year:

ASSOCIATE MEMBERS

When an associate member is applying for full membership status, biographical information must again be requested from AMA by the secretaries of the component societies.

COMPLETING MEMBERSHIP APPLICATIONS

The two regular member-endorsers must be members of the same component society to which the applicant is applying.

MEMBERSHIP ASSESSMENTS

Regular and associate members who have been dropped from the membership rolls for non-payment of the annual assessment cannot be reinstated until such indebtedness has been discharged, but such indebtedness shall apply only to one year of delinquency.

REINSTATEMENT OF MEMBERS

The committee on February 7, 1960, issued a ruling that "former regular or associate members whose memberships have lapsed for any reason must submit applications for committee approval before they may again be accepted as members." Enforcement of this rule resulted in some confusion, because no time limit has been stipulated.

The committee approved the followng formula for determining the eligibility for reinstatement of associate and regular members who have been dropped from the membership rolls for nonpayment of dues:

> If a member is dropped on June first and his assessment is received before the end of the same calendar year, he is to be reinstated immediately; but if the assessment is received after the end of the calendar year in which the member was dropped on June first, the rule will apply and an application must be submitted for committee action.

TRANSFERS

An applicant for membership by transfer, from a component society in this or any other state, who does not hold regular membership —including the right to vote and hold office in that component society—must serve a probationary period of one to two years as an associate member. At the discretion of the component society, a regular member so transfering may be elected to membership without serving a probationary period.

An associate member desiring transfer from one component society to another shall be required to resubmit a membership application for committee action as in the case of original applicants. This stipulation does not apply to regular members so transfering.

Approved (page 440)

FINANCE AND BUDGET

David B. Allman, M.D., Chairman, Atlantic City

(Reference Committee "B")

A review of the expenses and accounts to date indicates that the individual accounts are sound and that a slight balance in the total budget can be anticipated.

JOURNAL

No budget appropriation has been requested for the publication of *The Journal*, office expenses, and travel. The Committee on Publication is to be congratulated once more for its continued excellent financial status. (*The Journal*, except for salary items, will continue to operate on its advertising income.)

Last sentence deleted (page 441)

MEDICAL STUDENT LOAN FUND

As authorized by the Board of Trustees and approved by the 1961 House of Delegates, surplus funds over $100,000, at the close of the 1960-61 fiscal year, were transferred to the Medical Student Loan Fund—on loan and without interest—to enable the Fund Committee to carry out its program. The transfer amounted to $60,000. Of this, $29,000 was paid out in loans during the past year. The balance of $31,000 will, it is estimated, cover loans in the coming year.

AMERICAN MEDICAL EDUCATION FOUNDATION

It is noted that AMEF will consolidate with the American Medical Research Foundation as of June 1, 1962, and will be known as American Medical Association-Educational Research Foundation (AMA-ERF).

For the past three years, the House of Delegates has set the per capita level of contribution to AMEF in addition to, and not as part of, the budgetary assessment, with both being paid at the same time.

This method of contribution has resulted in maintaining the budget on an equalized basis. It has also resulted in a larger contribution to AMEF—$31,072.12 in 1961. Your committee definitely feels this method of contribution should be continued.

1963 ASSESSMENT

The computation of cash surplus at the close of the current fiscal year is estimated at $102,-937.33—slightly above the $100,000 sum which has been indicated as the desired surplus amount at the beginning of each new fiscal year.

The actual 1962-63 budgetary requirement is $39.91 per capita. Although the proposed budget for 1962-63 is increased only approximately $5,000 over 1961-62, an increase in the assessment of $5 per capita is required inasmuch as $10,700 was used from Surplus last year to keep the assessment at $35 per capita.

The committee noted that the Proposed Relative Value Index for New Jersey will come before the House of Delegates again this year and that probably a final vote on the proposal will be taken. If the proposal is adopted, copies will have to be printed and distributed to the membership. This additional expense has not been figured in the proposed budget for next year, nor has it been figured in the 1963 per capita assessment. If the Proposed Relative Value Index is adopted by the House, the 1963 per capita assessment should be increased, or an additional assessment should be levied, to cover the cost of the project.

1962-63 BUDGET

The proposed budget for 1962-63, in the total amount of $223,748, has the approval of the Board of Trustees. As recommended by the 1961 House of Delegates, the committee is listing "a breakdown of explanatory footnote on any item showing a marked difference between current and proposed budget."

RECOMMENDATIONS

1) That the per capita level of contribution to AMA-ERF (American Medical Association-Education Research Foundation) for 1963 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Adopted (page 441). NOTE: No action was taken by the House to set the per capita level of contribution to AMA-ERF for 1963

2) That the budget for 1962-63 be adopted in the total sum of $223,748.

Adopted (page 441)

3) That the 1963 assessment be adopted at $40 per capita, with no provision for a contribution to AMA-ERF.

Adopted (page 441)

PROPOSED BUDGET FOR 1962 - 1963

	Proposed 1962-63 Budget	Footnote	(Current 1961-62 Budget)
A- 1—Executive Salaries	$ 44,487.00	*	($ 55,108.00)
A- 2—Executive Office Salaries	61,657.00	*	(52,635.00)
A- 3—Executive Office Expenses	1,950.00		(2,000.00)
A- 4—Executive Travel	2,625.00	*	(2,405.00)
A- 5—House Maintenance	16,547.00	*	(15,825.00)
A- 6—Treasurer	3,730.00	*	(3,130.00)
A- 7—Committee on Finance and Budget	100.00		(100.00)
A- 8—Secretary	650.00	*	(1,300.00)
A- 9—Salary Taxes	3,286.00	*	(2,625.00)
A-10—Insurance	4,534.00	*	(3,634.00)
A-11—House Reserve	5,000.00	*	(..)
B —Journal Publication and Office Expenses	..		(..)
C- 2—Council on Legislation	7,500.00		(7,500.00)
C1 3—Council on Public Health, and 8 Special Committees	2,300.00	*	(1,700.00)
C- 4—Council on Public Relations	9,250.00	*	(10,000.00)
C- 5—Council on Medical Services, and 2 Special Committees	1,300.00	*	(1,100.00)
D- 1—President and Presidential Officers	11,240.00	*	(11,800.00)
D- 2—AMA Delegates	8,030.00	*	(5,260.00)
D- 3—Woman's Auxiliary	3,975.00	*	(8,027.00)
D- 4—Committee on Medical Education	325.00	*	(100.00)
D- 5—Conference Groups	500.00	*	(1,000.00)
D- 6—Committee on Credentials; Membership; Directory; and Physicians Placement Service	5,662.00	*	(3,750.00)
D- 7—Committee on Disaster Medical Services	100.00		(100.00)
D- 9—Archives and History	100.00		(100.00)
D-10—Blood Bank Commission	250.00		(250.00)
D-11—Committee on Medical Defense and Insurance	450.00	*	(750.00)
E- 1—Board of Trustees	6,000.00	*	(6,400.00)
E- 2—Contingent	10,000.00		(10,000.00)
E- 3—Judicial Council	900.00		(900.00)
E- 4—Legal	6,300.00		(6,300.00)
E- 6—Medical Student Loan Fund	5,000.00		(5,000.00)
TOTAL	$ 223,748.00		($ 218,799.00)

Adopted (page 441)

*FOOTNOTES

A- 1—Decrease due to modification of position of Assistant Editor for 1962-63, and salary cost transferred to A-2 account.

A- 2—Increase due to job reclassifications with higher salaries, regular annual increments, and transfer of salary charges for Assistant Editor (from A-1) and Auxiliary work (from D-3) to this account.

A- 4—Increase due to additional allowance required for AMA meeting on west coast.

A- 5—Increase due to higher property tax rate in Trenton.

A- 6—Increase due to added time required by bookkeeping service and auditing firm.

A- 8—Decrease due to deletion of expenses of Secretary to AMA meetings, as Secretary is now an AMA Delegate.

A- 9—Increase due to rise in salary tax rates.

A-10—Increase due to inclusion of projected 42 per cent rise in Blue Cross rates for employees.

A-11—New account—to provide a budgetary reserve account to spread over the years the costs of capital house expenses and periodic large maintenance costs and equipment purchases.

C- 3—Increase due to additional allowance in line with expenses of current year.

C- 4—Decrease due to reduction in allowance for anticipated projects and revision of mailing list for Health Hints.

C- 5—Increase due to additional allowance in line with expenses of current year.

D- 1—Decrease due to reduction in allowance in line with expenses of current year.

D- 2—Increase due to additional allowance required for AMA meeting on west coast.

D- 3—Decrease due to transfer of salary charges for Auxiliary work to the general salary account (A-2).

D- 4—Increase due to inclusion of allowance for Intern Survey.

D- 5—Decrease due to reduction in allowance in line with expenses of current year.

D- 6—Increase due to additional allowance for revision and printing a new supply of Membership Application Forms, and to provide one-half of the estimated net cost for publication of the 1963-64 Membership Directory.

D-11—Decrease due to reduction in allowance in line with expenses of current year.

E- 1—Decrease due to reduction in allowance in line with expenses of current year.

HONORARY MEMBERSHIP

F. Clyde Bowers, M.D., Chairman, Mendham

(Reference Committee "H")

No nominations were submitted to the Committee on Honorary Membership. Consequently, no meetings of this committee were held during the past administrative year.

Approved (page 450)

MEDICAL DEFENSE AND INSURANCE

Daniel F. Featherston, M.D., Chairman, Asbury Park

(Reference Committee "D")

During 1961-62 the Committee on Medical Defense and Insurance has met four times with a large majority of the committee present at each meeting. The committee is more than satisfied with the carriers who are presently writing the various insurance coverages for The Medical Society of New Jersey. Aspects of these coverages follow.

PROFESSIONAL LIABILITY

The 1960 annual report of this committee contained the proposal of the American Liability Insurance Company, a portion of which stated:

> We have no confidence in the rates established by the National Bureau or in its classifications. We have agreed to use them, however, until the actual experience of the group has enough validity to dictate what these should be. We repeat that all experiences (loss information) developed by the group will be available to the Society or its independent actuarial counsel. The rates and classifications will come from this experience. The rates could go down. More likely, however, the rates may go up.

The review of our premium and losses for the policy period expiring November 1, 1961, is very disappointing when we apply the experience in California, which is fairly creditable after 15 years. The total premium for professional liability earned for the policy period expiring November 1, 1961, was approximately $263,000. As of the same date, our losses, based almost completely on reserves, totaled about $93,000. Based on experience in California, where there is considerable delay in filing the claims, and for all purposes, no Statute of Limitations, we found that losses at the end of the policy year represent approximately 25 per cent of the final loss picture. Therefore, if we multiply $93,000 by 400 per cent we arrive at a very poor loss picture. We do not believe that our experience here will be identical to California, but until we do have statistics, we cannot arrive at a projection percentage.

The National Bureau of Underwriters announced a rate change, effective January 31, 1962, for all classifications in New Jersey, of approximately 30 per cent. In accordance with the original agreement, American Mutual will follow the National Bureau rates until it has creditable experience of its own. On the basis that creditable experience to project a rate loss is unavailable after only one year of operation, and because it was originally agreed to use National Bureau rates "until the actual experience of the group has enough validity to dictate what these should be," the committee unanimously agreed with the company's plans to increase the rate approximately 30 per cent effective May 1, 1962.

The experience of claims for the American Mutual is incomplete because of the delay in reporting incidents or delay in filing claims. Considering unreported losses, which is pure speculation at this time, it appears that the trend has not changed and probably will not until we do something about it. This committee feels that the American Mutual Loss Control Program should help to curb or even reverse this trend but, to be successful, a majority of physicians in each county must be insured under the officially endorsed program. Under this program, for the first time, the members of our Society assist in determining whether claims should be settled or defended. By settling the cases of liability and strenuously fighting those of no liability or of a blackmail nature, we should be able to im-

prove our position. The program has no place for nuisance settlements even though successful defense may cost ten times as much as the settlement figure, and there can be no settlement for expediency of the insurance company.

The participation in this program by the members of our Society is only fair on a statewide basis because of the lack of interest or knowledge on the part of the members of a few county societies. Participation is as follows:

County	Active Members as of 10-1-61	Insured as of 3-1-62	Percentage
Atlantic	160	9	6
Bergen	681	433	64
Burlington	113	24	21
Camden	357	20	6
Cape May	38	7	18
Cumberland	94	36	38
Essex	1,545	930	60
Gloucester	64	10	16
Hudson	627	232	37
Hunterdon	54	40	74
Mercer	412	110	27
Middlesex	331	220	66
Monmouth	326	243	74
Morris	271	172	63
Ocean	81	25	31
Passaic	581	326	56
Salem	49	3	6
Somerset	96	77	80
Sussex	41	32	78
Union	600	355	59
Warren	40	20	50
State Total	6,561	3,324	51

If the interests of all physicians in New Jersey are to be considered, then each member should immediately insure with our official carrier. The participation in 16 counties is 57 per cent over a period of approximately 17 months, but in the other five counties it averages only 7 per cent. We feel that to have the greatest success, we should have at least 70 per cent of our members insured under the official program.

As previously stated, the experience as to incidents reported is inadequate, and a creditable report will not be available until next year. However, through February 28, 1962, the company has received 60 reports of incidents as follows:

County	Policy Period Expiring 11-1-60	11-1-61	11-1-62	Total
Atlantic	0	0	0	0
Bergen	1	7	1	9
Burlington	0	0	0	0
Camden	0	0	0	0
Cape May	0	0	0	0
Cumberland	0	0	1	1
Essex	0	16	4	20
Gloucester	0	0	0	0
Hudson	0	1	1	2
Hunterdon	0	0	0	0
Mercer	0	1	0	1
Middlesex	0	1	0	1
Monmouth	0	3	0	3
Morris	0	2	3	5
Ocean	0	0	0	0
Passaic	0	4	1	5
Salem	0	0	0	0
Somerset	0	0	1	1
Sussex	0	0	0	0
Union	1	7	4	12
Warren	0	0	0	0
State Total	2	42	16	60

An analysis of these 60 incidents, as to specialty or classification, shows the greatest volume in anesthesiology, but all of these claims are of a relatively minor nature with the most involving damage to a tooth while intubating. The next group with highest frequency is general surgery. Here we find a few serious cases. The most expensive group as to potential loss is that of injections—two deaths due to anaphylactic shock, and a foot drop in a six-year old girl. The analysis is as follows:

Obstetrics-gynecology	4
Surgery-general	9
Surgery-plastic	1
Surgery-orthopedics	1
Anesthesiology	12
Urology	1
Internists	2
Pediatrics	5
General falls	8
General needle injections	6
General prescriptions	2
General improper diagnoses	5
General miscellaneous	4
TOTAL	60

Adopted (page 441)

LOSS CONTROL PROGRAM

One year's experience with loss control committees has been gratifying. The cooperation between the committee, the carrier, and the defense attorneys has been excellent.

Experience would indicate that a committee of five to seven members is the ideal size. The larger committees appointed by some of the more populous counties have proved to be cumbersome. Incoming county presidents might do well to bear this fact in mind, and perhaps the larger counties could break down their committees into three or four subcommittees of from five to seven members. Continuance of more experienced members on committees for three to five years is urged.

Recommendation of reference committee adopted: That the Loss Control Committee consist of 9 to 12 members and, when necessary, include seasoned individuals from other specialties on temporary membership basis, only for specific instances (page 444)

PREMISES LIABILITY

Premises liability coverage is available at relatively low rates—for the majority $15.40 per year for $100,000 per claim/$300,000 per accident for bodily injury. Rates, based on square foot area and locality, will be supplied by American Mutual upon request.

Approved (page 444)

ACCIDENT AND HEALTH

There is now available accident and health insurance up to $1,200 monthly benefit under the basic program of five years for accident and two years for sickness—$600 monthly benefit under the original accident and health insurance program with the National Casualty Company, and $600 monthly benefit under the additional program with the Nationwide Mutual Insurance Company.

Long term coverage of up to $600 monthly benefit is available under the Extended Professional Disability Policy of the National Casualty Company. This policy steps in, in the event of a long extended disability, to continue accident benefits for life and sickness benefits for an additional five years.

(The above indicates two extensions of coverage just announced by the respective companies. The National Casualty Company has increased the monthly benefit available under the Extended Professional Disability Policy from $400 per month to $600 per month; and the Nationwide Mutual Insurance Company has just increased the monthly limits available under its policy from $400 to $600 per month.)

There are presently in force 3,765 policies with the National Casualty Company and 1,362 with the Nationwide Mutual Insurance Company. The National Casualty Company has paid 463 accident and health claims in the past year for a total of $343,000. The highest claim paid to any one individual was $7,100, and the lowest was $13.33. Under the Nationwide Mutual Insurance Company policy, 56 claims were paid for a total of $28,000; the highest, $1,653.33, and the lowest, $53.33.

Approved (page 444)

MAJOR MEDICAL EXPENSE

This policy was approved by the Board of Trustees in July 1961—following referral of the matter to the Board for study and action by the 1961 House of Delegates—and members of the Society are presently being enrolled. The policy, underwritten by the National Casualty Company, provides benefits up to a maximum of $10,000 for any one sickness or accident, with a $500 deductible and an 80/20 co-insurance clause. At present more than 1,100 members have applied for this insurance. The administrator, E. & W. Blanksteen Agency, Inc., plans a concentrated enrollment campaign by counties to achieve the required 50 per cent minimum participation in order to include impaired risk applicants and impaired risk dependents. Policies are presently being issued only to those applicants who meet company underwriting requirements.

A greater percentage of applications has been received from the large northern counties with reduced support from the smaller southern counties. There must be over-all support by *all* counties if impaired risk members are to be included at an early date.

Approved (page 444)

LIFE INSURANCE

This program with the Nationwide Life Insurance Company was inaugurated in March 1959. It presently has 1,794 members insured for a total of $22,150,000. Since the report of April 1961, there have been 19 deaths—all claims paid for a total of $190,000. Of these, 14 were impaired risks when insured and were included by virtue of our having achieved the required quota. Otherwise, they would not have received insurance on an individual basis. Since the inception of the program, 32 death claims have been paid. There are no claims pending.

Approved (page 444)

The committee especially wishes to thank Mr. Joseph Britton, New Jersey Manager for the American Mutual Liability Insurance Company, and Mr. William Blanksteen of the E. & W. Blanksteen Agency for their continued cooperation and attendance at the meetings of the committee when requested. They have been most helpful and, we feel, personally interested in the welfare of the members of The Medical Society of New Jersey.

We extend our appreciation also to our Executive Officer, Mr. Nevin; Administrative Secretary, Mrs. Madden; and Counsel, Mr. Backes, for their assistance and guidance in our procedures.

RECOMMENDATIONS

1) That the contract with the American Mutual Liability Insurance Company for the professional liability insurance program be continued.

Approved (page 444)

2) That the services of the E. & W. Blanksteen Agency be continued as the Society's official broker for the accident and health, major medical expense, and life insurance programs.

Approved (page 444)

Recommendation of reference committee adopted: That county societies give their complete support to these various programs. The committee noted that there is low percentage of participation in the overall insurance program in various counties.

MEDICAL EDUCATION

Sherman Garrison, M.D., Chairman, Bridgeton

(Reference Committee "D")

In line with the committee's report last year —that modification of the function of this committee, which no longer seems pertinent, should be made—recommended changes in the Bylaws were drafted. These were approved by the Board of Trustees and referred to the Committee on Revision of Constitution and Bylaws.

The committee has under study the possibility of surveying the current and projected educational programs in New Jersey on various levels—county society, hospital, specialty group, and college.

Another item under study is the possibility of an intern questionnaire to hospitals, for the general purpose of improving the intern and resident situation in our hospitals.

The committee will continue working on these projects, reporting its progress periodically to the Board of Trustees.

The Bylaws provide that this committee shall serve as the contact group with the medical and dental schools in this State. No liaison problems have been presented from the Seton Hall College of Medicine and Dentistry. The committee is maintaining a general interest in the formation of a two-year medical school at Rutgers University.

Approved (page 444)

MEDICAL STUDENT LOAN FUND

Luke A. Mulligan, M.D., Chairman, Leonia

(Reference Committee "B")

In its five years of operation, the Medical Student Loan Fund has granted a total of $58,975.35 in 63 loans to 49 New Jersey medical students.

The gross fund totals $83,194.16—$76,252.16, General Fund; $5,512, Albert Barker Kump Memorial Grant; $1,430, Joseph E. Mott Memorial Grant.

The 1961 House of Delegates authorized that all funds in the surplus account in excess of $100,000 at the close of the 1960-61 fiscal year be made available to the Fund on loan without interest. As a result of this action, $60,000 was transferred to the Fund, $30,000 of which was granted in loans this year to 31 students.

The committee is grateful to the many contributors to the fund and takes this occasion to acknowledge their support. A list of contributors to date (4/16/62) since the last report follows:

Albert Barker Kump Memorial Grant—Cumberland County Woman's Auxiliary, in honor of Dr. Joseph A. Bonaccorsi; Dr. and Mrs. Joseph Ziegler; Mrs. Charles Cunningham.

General Fund—State Auxiliary Executive Board and Fellowettes; County Auxiliaries: Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Mercer, Middlesex, Ocean, Passaic, Somerset, and Warren; State Auxiliary Fellowettes, in memory of Dr. Lewis C. Fritts; State Auxiliary Fellowettes, in honor of Mrs. Richard J. McDonald; Atlantic Auxiliary, honoring wives of physicians in recognition of their services to Shore Memorial and Atlantic City Hospitals; Salem Auxiliary, in honor of Williams Brothers Printing Company, and Mrs. W. Garrett Hume; Passaic Auxiliary, honoring "needy students"; Bergen Auxiliary, in memory of Dr. Leo J. Fitzpatrick and Dr. Lewis C. Fritts; Camden Auxiliary, in memory of Mrs. Charles Volpe and Mrs. Ernest E. Manser; Cumberland Auxiliary, in memory of Mrs. Mario Pastore and Miss Mabel DeStefanio; Salem Auxiliary, in memory of Mrs. Michael S. Cettei. County Societies: Mercer County, in memory of Dr. Henry J. Majeski and Dr. Leonard Weinstock; Somerset County, in honor of Bound Brook Adult School. State Society, in memory of Mrs. Daniel F. Featherston. Individual contributions: Mrs. Abraham Goldstein, in honor of Dr. Dodd's recovery; Dr. and Mrs. Victor Ruby, in honor of Community Day Meeting participants; Dr. Mary Bacon, Dr. and Mrs. Carl N. Ware, Dr. F. Clyde Bowers, Dr. Samuel J. Lloyd, Dr. and Mrs. Louis S. Wegryn—in memory of Dr. Aldrich C. Crowe; Dr. and Mrs. R. W. Gosper, in memory of Dr. William J. Browning; Dr. and Mrs. Millard Cryder, in memory of Raymond Errickson and William F. Ziegler; Dr. and Mrs. Paul R. Sparks, in memory of Dr. Jacob M. Davis and Michael Ziccardi; Dr. and Mrs. John F. Kustrup, in memory of Diran Majarian, D.D.S., Dr. Henry J. Majeski, George J. Bayen, and John T. Brammer; Dr. and Mrs. Floyd D. Gindhart, in memory of Michael Kustrup and Richard P. Hughes; Miss Edith Williams, in memory of Michael Kustrup; Dr. and Mrs. John Scillieri, in memory of Albert Reilly; Dr. and Mrs. Rubin Grossman, in memory of Mr. and Mrs. Rosenberg; Dr. and Mrs. Paul E. Rauschenbach, in memory of Gustave Rauschenbach, A. Ianacone, Henri C. Mathey, Twining Campbell, Mrs. Hans Wassing, Father and Brother of Miss Catherine Hehn, Dr. Frank Vanderbeek, and a relative of J. Spencer; Dr. Frank L. Rosen, in memory of Dr. Simon Ruskin and Dr. Philip Oginz; Dr. and Mrs. Paul B. Ferrary, in memory of Mrs. Nellie Adams and Gregory Bogush; Mrs. Thomas P. McConaghy and Mrs. Ira Sauerman, in memory of Dr. Thomas P. McConaghy; Mrs. Ruth Colsman and Mrs. Olga Hulsiger, in memory of Sabino Ianacone;

Also, Dr. and Mrs. J. A. Rogers, in memory of Dr. F. Vanderbeek, Sr.; Dr. and Mrs. J. Rube, in memory of A. Rubin, Dr. Peter Pagano, Dr. F. Vanderbeek, Sr., and Gwendolyn Stafford; Dr. and Mrs. Joseph Ziegler and Dr. and Mrs. Paul B. Sparks, in memory of Mrs. Young; Dr. and Mrs. Walter S. Booth, in memory of Dr. L. Herling Jones and Dr. Paul E. Bechet; Mrs. James C. Tsucalas, in memory of Speros A. Versis; Dr. and Mrs. Igino Grossi, in memory of Mrs. LaPaso and Peter Primmer; Mrs. Gibbs, Mrs. Purwin, Mrs. Cadenazzi, Mrs. Chelton and Mrs. Ianacone—in memory of Miss Priscilla Hall; Dr. and Mrs. C. S. Tarta, in memory of Joseph Jenco, Sr., Miss Edythe Zappo, and Benedetto Ricucci; Dr. and Mrs. J. D. Brenna, in memory of Dr. Benjamin Salway; Dr. and Mrs. A. A. Allen and Mrs. Marie Meninger, in memory of Mrs. F. Lomauro.

The following chart is supplied in accordance with the recommendation of the 1961 House of Delegates "that future reports of the committee include a breakdown of the loans granted—by county of residence and medical school attended":

County of Residence	Medical School	Number of Students	Loans Granted 1957-61	Loans Granted 1961-62
Atlantic	Hahnemann	1	$	$ 1,000.00
Bergen	Hahnemann	1		1,000.00
	Seton Hall	2		2,000.00
	Woman's Medical	1		1,000.00
Burlington	Duke	1		1,000.00
	Jefferson	1	2,000.00	
Camden	Jefferson	1	1,000.00	
	Michigan	1		1,000.00
	Seton Hall	1		1,000.00
	Temple	1		500.00
Cumberland	Jefferson	1	1,000.00	1,000.00
Essex	Bern	1	2,325.35*	
	N. Y. Medical	1	1,000.00	
	Seton Hall	3	1,000.00	3,000.00
	St. Louis	1		500.00
	Temple	1	1,000.00	
Gloucester	Temple	1	2,000.00	
Hudson	Harvard	1	1,000.00	
	Howard	1	400.00	
	Seton Hall	8	3,000.00	7,000.00
	St. Louis	1		1,000.00
Mercer	Hahnemann	2	3,000.00	
	Howard	1	1,000.00	
	Meharry	1	250.00	
	Seton Hall	2	2,000.00	1,000.00
	St. Louis	1	700.00	
Middlesex	N. Y. Med.	1	2,000.00	
Monmouth	Seton Hall	2	1,500.00	2,000.00
Passaic	N. Y. Med.	1		1,000.00
Somerset	Temple	1	1,000.00	1,000.00
	Western Reserve	1	1,000.00	
Union	Seton Hall	5	800.00	4,000.00
14 Counties	14 Medical Schools	49 Students	$ 28,975.35	$ 30,000.00

*Includes payment of insurance premium.

Approved (page 441)

PUBLICATION

Fred B. Rogers, M.D., Chairman, Trenton

(Reference Committee "B")

During the last twelve months our JOURNAL has been widely quoted in the four corners of the nation. Doctor Davidson's editorial on the "Morning Snack" was reprinted in North Carolina, and "When a Body Kiss a Body" was extensively quoted in the West Virginia Medical Journal. *Coffee Break,* an editorial we published in 1959, was still being cited in 1962. A Texas Hospital used Doctor Davidson's *Ephebiatrics* editorial in developing a special adolescent service. Several newspapers quoted "Stench in the Ear" from last August's JOURNAL. Many of our original articles were condensed by national abstracting services for nationwide release.

A tabular comparison of the last four years will be of interest. The "State Activities" line below includes obituaries, civil defense material, and auxiliary items. Numerals here indicate number of pages.

	1958	1959	1960	1961
Book Reviews	19	23	25	33
Original scientific articles	291	389	324	255
Editorials	32	29	30	34
Historical material	41	13	11	6
State Activities	241	242	280	240
Letters and announcements	19	21	15	19
County society reports	29	31	33	25
Total of text material	672	748	718	612
Advertising	1084	1162	1124	844
Grand Total of pages	1756	1910	1842	1456
Ratio: advertising/text	52%	61%	62%	56%

The drop in advertising budgets of pharmaceutical companies was first noticed last year. In 1960 there was a nationwide cut of 10 per cent in medical journal advertising. We experienced only a 4 per cent decline—from 1,162 to 1,124 pages. However, between 1960 and 1961, advertising declined from 1,124 to 844 pages, a drop of 24 per cent, paralleling a national fall of 20 per cent in journal advertising. To remain within our budget, we were obliged to reduce the amount of text material in the JOURNAL, though not by that extent. Text material fell from 718 to 612 pages, a decline of only 15 per cent. We have maintained our unusually large book review service—in fact we devoted 33 pages to it in 1961. This has become a popular feature of our JOURNAL, appreciated by our readers and by publishers.

In 1961 we published 67 original scientific articles, nearly all of them by New Jersey physicians. (The few papers by out-of-state authors represented material delivered at meetings in New Jersey.)

I cannot close this report without commenting on the retirement of Mrs. Armstrong who, for many years, kept the wheels turning in the editorial office. She assumed full responsibility for bookkeeping, advertising, lay-out, billing, and proof-reading and also for the secretarial and administrative details of the editorial office. She will be missed by the Publication Committee and, I am sure, by the editor, too.

This is my last year as chairman of the Publication Committee. Increasing responsibilities in teaching and practice made it impossible for me to give this JOURNAL the attention it merits. It has been a pleasure to serve in this capacity for these five years. I am working on the preparation of our Society's bicentennial history for 1966, and will continue as Archivist; I thus remain devoted to, and interested in, serving The Medical Society of New Jersey.

The Trustees have designated Miss Theresa E. Goeke as editorial secretary. On the basis of her work to date, I know that she will be a valuable addition to the JOURNAL staff; and on behalf of the Committee we say we are glad to have her with us.

The JOURNAL operates with quiet efficiency, and no changes are contemplated or recommendations made at this time.

Approved (page 441)

Recommendation of reference committee adopted: That, in future years, the Publication Committee make a complete financial statement as part of its report.

REVISION OF CONSTITUTION AND BYLAWS

Louis F. Albright, M.D., Chairman, Spring Lake

(Reference Committee on Constitution and Bylaws)

The standing Committee on Revision of Constitution and Bylaws, as required under Chapter XII of the Bylaws, studied the proposed amendments to the Bylaws approved and referred to the committee by the Board of Trustees on recommendations of the Council on Public Relations (page 397) and the Committee on Medical Education (page 380).

COMMITTEE AND COUNCIL VACANCIES

It was the unanimous opinion of the committee that this amendment should be permissive rather than mandatory.

Original Recommendation

That the appropriate section of the Society's Bylaws be amended to include the following proviso:

If a member of a council or committee—either appointed by the President or elected by the House of Delegates—absents himself from two consecutive meetings without excuse, he shall be presumed to have vacated his position on the council or committee, and the President shall fill the vacancy pro tem.

Committee's Proposal

CHAPTER IX — ADMINISTRATIVE COUNCILS AND COMMITTEES

Section 2 — Qualifications, Selection and Terms of Members

Add the following paragraph:

(g) If a member of a council or committee, either appointed by the President or elected by the House of Delegates, absents himself from two consecutive meetings without excuse, it may be presumed that he has vacated his position on the council or committee, and the President may fill the vacancy until the next annual meeting.

Adopted (page 438)

COMMITTEE ON MEDICAL EDUCATION

The Committee on Medical Education in its 1961 annual report, requested "modification of the present constitution delineation of the function of this committee, which no longer seems pertinent." It therefore proposed that the problems of graduate medical education and of intern and resident training should be of some continuing interest to the Medical Socity; and it felt that this is the logical committee for such activity.

The chairman of the Committee on Medical Education was present at the meeting of the Committee on Revision of Constitution and Bylaws, and expressed dissatisfaction with the wording of his committee's proposed amendment. With his approval the Committee on Revision of Constitution and Bylaws revised the proposal.(*)

Original Recommendation

CHAPTER IX—ADMINISTRATIVE COUNCILS AND COMMITTEES

Section 14 — Committee on Medical Education

Add the following paragraphs:

(c) This committee should maintain an active interest in and make recommendations to The Medical Society of New Jersey with regard to the continuing medical education of its members.

(d) This committee shall also maintain a continuing interest in the intern and resident training program in the State.

*Committee's Proposal

CHAPTER IX—ADMINISTRATIVE COUNCILS AND COMMITTEES

Section 14 — Committee on Medical Education

Add the following paragraphs:

(c) This committee shall maintain an active interest in the continuing medical education of the members of this Society.

(d) This committee shall maintain a continuing interest in the intern and resident training program in the State.

Adopted (page 438)

ADVISORY TO WOMAN'S AUXILIARY

Volmar A. Mereschak, M.D., Chairman, Phillipsburg

(Reference Committee "H")

Under the excellent and diligent leadership of its President, Mrs. Floyd D. Gindhart, the Woman's Auxiliary successfully achieved the goals it had set at the beginning of the year. The Advisory Committee to the Woman's Auxiliary extends its congratulations and thanks to the President of the Auxiliary, and to all the other officers and members who worked so hard to make this a successful year.

Following the precedent of other years, at the beginning of the administrative year the official programs and projects for the year were submitted and cleared through the Board of Trustees.

The programs of the Woman's Auxiliary are all intended to serve in a supporting capacity the programs and purposes of The Medical Society of New Jersey and its component societies. As part of its program, the Auxiliary has served on the editorial committee and aided in the compilation of the "Health Careers Guidebook." In connection with this project, a survey was initiated to determine the number of members of senior Future Nurses' Clubs who entered schools of nursing or allied health fields in 1960 and 1961.

To further the cause of medicine, the Auxiliary presented at county levels—with county society approval—planned programs having teaching and guidance value for more effective community activity. Also, in the realm of public relations, the Auxiliary has continued educational programs for auxiliary members to maintain an informed auxiliary on health subjects and the medical profession.

It is a pleasure to note the way in which coordination of endeavor and cooperation of efforts between The Medical Society of New Jersey and its Woman's Auxiliary exist. This tends to make a strong and effective organization which, in the final analysis, benefits the people and the medical profession in this State.

Approved (page 450)

NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1962 annual meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

BERGEN COUNTY

John K. Crandall, Fort Lee; age 70
Henry D'Agostin, Wyckoff; age 65
Lester W. Netz, Vero Beach, Florida (formerly Hackensack); age 62

CAMDEN COUNTY

Mabel S. Haines, Audubon; age 79
Ernest B. Shaw, Camden; age 77

ESSEX COUNTY

Arthur R. Abel, Great Meadow; age 63
Louis M. Bull, Maplewood; age 68
Samuel A. Goldberg, West Orange; age 72
Wilson G. Guthrie, Newark; age 65
Nathan B. Heller, East Orange; age 69
Archibald Lyon, Arlington; age 61
Martin M. Meehan, Chester Township; age 66
Royal A. Schaaf, Califon; age 70
Louis Shapiro, Newark; age 63
Ellis L. Smith, Denver, Colorado (formerly Belleville); age 64
James H. Willson, Hendersonville, North Carolina (formerly East Orange); age 63

HUDSON COUNTY

Louis A. Pyle, Jersey City; age 70

PASSAIC COUNTY

John J. Szymanski, Spring Lake (formerly Passaic); age 75

Approved (page 450)

Supplemental Nominations

PASSAIC COUNTY

Florence Slaff, Passaic; age 65

UNION COUNTY

Charles T. Decker, Albion, N. Y. (formerly Westfield); age 78
Paul Geary, Plainfield; age 64
Julius Gerendasy, Elizabeth; age 70
Thomas J. Walsh, Fort Lauderdale, Fla. (formerly Elizabeth); age 64

SUSSEX COUNTY

George F. Johnson, Branchville; age 72
Fred H. Morrison, Newton; age 73
Thomas L. Pellett, Hamburg; age 76

Approved (page 450)

Special Committees • • •

NURSING EDUCATION

Irving M. Levitas, M.D., Chairman, Westwood

(Reference Committee "H")

The committee's first meeting concerned itself with exploring the physician's point of view regarding the problem of nurse recruitment. This was followed by an exploratory conference with representatives from the New Jersey State Nurses' Association. After that a similar meeting was held with representatives from the New Jersey Hospital Association. In April a meeting was held with directors of hospital nursing schools in the state. Informal conferences have been held also with representatives from the State Department of Education.

It is not possible as yet to give any conclusions, as further meetings will be necessary to formulate a definite program. Considerable information is being accumulated from which the final report can later be made.

Approved (page 450)

PHYSICIANS PLACEMENT SERVICE

Samuel J. Lloyd, M.D., Chairman, Trenton

(Reference Committee "D")

To fulfill more effectively the purpose of the committee and to operate in closer cooperation with the AMA Placement Service and component societies, the Physicians Placement Service was reviewed and extensively revised this year. As a result, there has been increased activity in this phase of the Society's operations.

All physicians who contact The Medical Society of New Jersey—or are referred to it by the American Medical Association—are sent an information form, requesting personal data and other relevant details pertaining to their professional education and training. These completed data-sheets are utilized as the basis for a compilation titled "Physicians Seeking Location in New Jersey."

Requests from physicians or communities seeking the services of a physician are handled in a similar fashion. Questionnaires are supplied to them, requesting supplemental information which will enable the physician and location to team up on a compatible basis. These completed forms become the basis for the compilation titled "Opportunities for Practice in New Jersey."

Both compilations are revised on a quarterly basis and redistributed to component societies, the AMA, and all interested parties.

This year, as of April 6, there had been 273 inquiries from physicians interested in establishing practice in New Jersey—seventy per cent of which were referrals from the AMA Placement Service. During this period twenty-two physicians have located out of state and eighteen in New Jersey. The names of one hundred thirty-three physicians were dropped from the active list because of failure to respond to follow-up communications. There are 103 physicians currently registered with the service as seeking placement in New Jersey.

The requests for placement in the state have far exceeded the placement opportunities available. There are currently listed fourteen opportunities for practice in New Jersey: thirteen are for solo, general practice in communities with populations under 40,000; the other opportunity is for association with a general practitioner in a small southern New Jersey community. Most of the physicians registered with the Placement Service are seeking location as specialists, with either group or associate arrangements.

Below are listed preference indices for types of practice and practice arrangements, based on the Placement Service's 103 active registrants currently seeking placement in New Jersey:

PREFERENCE INDEX FOR

TYPES OF PRACTICE ARRANGEMENTS

Associate	1.95
Group	1.60
Solo	1.00
Institutional	.40
Industrial	.22
Locum Tenens	.07

PREFERENCE INDEX FOR

TYPES OF PRACTICE

Internal Medicine	1.87
Obstetrics and Gynecology	1.07
General Practice	1.00
Surgery	.87
Pediatrics	.53
Radiology	.53
Urology	.27
Anesthesiology	.20
Ophthalmology	.20
Pathology	.20
Cardiology	.13
Aviation Medicine	.07
Dermatology	.07
Orthopedics	.07
Psychiatry	.07

Because of the disparity between the number of physicians seeking to locate in New Jersey and the number of opportunities for placement available, we urge all our members who are seeking new associates, or who know of an opening for a new practitioner in their area, to make contact with the Placement Service.

Approved (page 445)

RETIREMENT PLAN FOR PHYSICIANS

Jerome G. Kaufman, M.D., Chairman, Maplewood

(Reference Committee "D")

In its 1961 report, approved by the House, this special committee declared:

"Since the AMA has appointed a committee to study the entire question of retirement plans, it has agreed that no action be taken at this time and that the committee await the report of the AMA committee and the action of the AMA thereon."

The 1961 House of Delegates approved Resolution #15, sponsored by the Mercer County Component Medical Society, which directed that:

"The retirement committee of The Medical Society of New Jersey be continued in office and investigate the possibility of obtaining the revision of the appropriate laws of the State of New Jersey, permitting the formation of medical corporations or associations."

Your committee, in its work during the year just ended, concerned itself with both of the foregoing matters.

In connection with the actions of the AMA Study Committee on Retirement Plans, your committee was informed by the AMA that its committee, with the approval of the AMA House of Delegates, declared "that any action with respect to a national group retirement program be deferred until favorable action by the Congress on H.R. 10 (87th Congress—Keogh).

Your committee, therefore, unanimously agreed that any action on a retirement program at state level should be deferred until action is taken on H.R. 10.

In connection with Resolution #15, your committee is pleased to report that a bill has been introduced into the Legislature of New Jersey (Senate 32—Ridolfi—known as "the Professional Service Corporation Act") to accomplish the intent of the Resolution. S-32 authorizes the creation of professional service corporations; provides definitions, exceptions, and the manner and method of creating such corporations. On recommendation of the Council on Legislation, the Society approved this proposed legislation as of February 18, 1962.

S-32 makes possible the establishment of a single shareholder corporation by means of the following stipulation:

"A professional corporation which has only one shareholder need have only one director, who shall be such shareholder. Such one shareholder shall also serve as the president of the corporation. The other officers of the corporation in such a case need not be licensed or otherwise legally authorized to render the same professional service within this state as such one shareholder."

Commenting on the legislation, Society's Legal Counsel cautioned the committee that, "with a change in legislation to permit the formation of medical corporations or associations in New Jersey, there would be considerable expense to physicians forming corporations or associations in order to comply with the law; and after their going through all the trouble and expense, the Internal Revenue Service could change its regulations to prevent the further loss of tax dollars, and all the work done and expense incurred would go down the drain."

Accepted (page 445)

Recommendation of reference committee adopted: That the state committee continue to investigate actively all possible avenues of programming retirement plans at state and local level, in addition to national level.

TRAFFIC SAFETY

A. M. K. Maldeis, M.D., Chairman, Collingswood

(Reference Committee "H")

This year marked an improvement in The Medical Society's relationship with the State Division of Motor Vehicles, in consequence of a series of conferences with Director Parsekian and other representatives of the Division. The Board of Trustees appointed the Traffic Safety Chairman as the Society's official liaison representative to the Division of Motor Vehicles, to facilitate contacts and to deal more promptly with common concerns.

DIVISION OF MOTOR VEHICLES

At the request of the Division, the Board appointed a three-member advisory panel, to function at state level, to assist the Director of the Division of Motor Vehicles in evaluating reports of physical examinations made upon drivers suspected of having disabling cardiac conditions.

SEAT BELTS

On recommendation of the Special Committee on Traffic Safety, The Medical Society of New Jersey went on record as supporting the encouragement and use of safety belts in motor vehicles.

Recommendation of reference committee adopted: That members of MSNJ add practice to precept, and have their own cars equipped with the safety devices recommended.

TESTIMONY IN DRUNKEN DRIVING

In cooperation with the State Board of Medical Examiners and the New Jersey State Safety Council, the Special Committee called to the attention of the membership, for their information and guidance, the pertinent portion of the Motor Vehicle Law concerning the testimony of physicians in those cases involving persons charged with driving under the influence of intoxicating liquor (Title 39:4-50.1). This information was published in the September-October 1961 issue of the *Membership News Letter*.

MEETING WITH STATE BOARD OF MEDICAL EXAMINERS

At the request of the Board of Medical Examiners, a joint meeting was held to discuss the interest of the Attorney General in working out possible solutions for problems confronting the Attorney General's department in conjunction with the operation of motor vehicles in New Jersey, in the endeavor to reduce the number of licensed New Jersey drivers who are not dependably fit to operate motor vehicles because of disease conditions.

Physicians have the opportunity and duty to emphasize to those of their patients who, by reason of disability or medication, should not be operating a motor vehicle, the hazards of driving—both to themselves and others.

STATE SAFETY COUNCIL

Regular meetings of the New Jersey State Safety Council, held in Newark, were attended by the Chairman throughout the year. The cooperation between our State government and the Safety Council rates among the highest in the states. Continued education and emphasis on observance of motor vehicle laws and regulations have been responsible for keeping the accident rate down in our State, although, of course, much remains to be accomplished.

Approved (page 450)

LEGISLATION

Samuel J. Lloyd, M.D., Chairman, Trenton

(Reference Committee "E")

The Council on Legislation met in regular session four times during the current administrative year. Representatives of the Council also met with special conference groups as requested:

1) New Jersey Chiropodists Society . . . to consider limited extension of the practice of chiropody by means of amendment of the present chiropody law.

2) New Jersey Blood Bank Commission . . . to evolve legislation to deal with licensure of blood banks in procuring and processing of human blood or human plasma for therapeutic or prophylactic purposes.

3) New Jersey Chapter of the American Physical Therapy Association . . . to explore the possibility of regulating the practice of physical therapy by means of an amendment to the Medical Practice Act to effect registration of qualified physical therapists by the New Jersey State Board of Medical Examiners, on terms acceptable to the New Jersey Chapter and The Medical Society of New Jersey.

At the request of the Board of Trustees, the Council—through its Legislative Analyst, who attends all meetings and conferences—drafted the following proposed legislation:

1) To amend the School Health Law . . . to permit any licensed physician to certify the physical fitness of a minor applying for working papers.

2) To amend the Beadleston Act . . . to include school physicians among the members of the child study team in item 2 of this law; and to provide "psychiatric" rather than "psychological" treatment of the disturbed children and to make such treatment the responsibility of the "family and appropriate family physician and/or consulting psychiatrist" rather than the school or county child study team.

In the 1962 Session of the New Jersey State Legislature, the following Society-sponsored measures were re-introduced:

1) *S-201 Ridolfi*—To amend the Medical Practice Act to permit medical and x-ray technicians to perform certain technical ancillary services to licensed physicians.

2) *S-204 Ridolfi, Deamer*—To authorize school medical inspectors to accept evidence of a satisfactorily performed examination by the family physician in lieu of the required school examination.

At its June 21, 1961 meeting, the Council unanimously agreed; and the Board concurred, that the Society should not introduce any other legislation "until some positive action was taken with regard to these two measures."

Thus, the Council currently has a backlog of four proposed bills which must await introduction until such time as the above two measures have achieved passage:

1) A bill to permit any licensed physician to certify the physical fitness of a minor applying for working papers;

2) A bill to amend the Beadleston Act;

3) A bill to outlaw entertainment hypnosis;

4) A "Good Samaritan" law, to protect from liability persons who in good faith render emergency service.

Upon recommendation of the Council, a one-year gift subscription to *"Today's Health"* was sent to each New Jersey state legislator from The Medical Society of New Jersey.

This year—as in preceding years—the Council strongly urged that all component societies and all specialty groups not commit themselves concerning pending state legislation until they have at least checked with The Medical Society of New Jersey, and that they not support legislation until they have convincing proof that it is consonant with the welfare of the people and the true good of medical practice. Only in this way can the members of MSNJ be afforded unified and effective representation, with protection of the public welfare. For component societies or specialty groups to act independently and antagonistically is to destroy the efficacy of the Society's legislative mechanism and the Society's influence in the area of legislation.

Since the opening of the 1962 State Legislative Session on January 9, the Council has considered the following bills. All measures thus marked (*) are identical with bills of last year (1961), and the official position of The Medical Society of New Jersey concerning them remains the same. The regular range of positions is: *Active Support* . . . all-out support for the measure; *Active Opposition* . . . all-out opposition to the measure; *Approval* . . . commended as satisfactory but not actively supported; *Disapproval* . . . rejected as unsatisfactory but not actively opposed; *No Action* . . . considered but not regarded as significant or relevant to the Society's interests at this time.

S-7 Sandman—To permit licensed physicians, sanitary inspectors, and executive officers of municipal boards of health to obtain a license as health officer without examination in certain cases. *Disapproval* . . . in adherence to the policy position taken by the House of Delegates of The Medical Society of New Jersey in 1961 and in support of the contention of the Commissioner of Health that such legislation would be "a retrogressive step in public health in New Jersey."

*S-12 Sandman—(Identical with A-27 and A-353) To establish a program of medical assistance for the aged, complementing the present program of old age assistance, and making provisions consistent with requirements for receiving federal matching funds. *Active Support*

*S-15 Dumont—To make certain diseases of volunteer firemen occupational diseases. *Disapproval* . . . because it involves diagnosis by legislative enactment rather than by medical investigation.

*S-26 Fox—To include within the definition of narcotic drugs any determined by the Health Commissioner to have addiction "liability" similar to morphine or cocaine. *Approval*

*S-27 Fox—To make possession by unauthorized persons of certain barbiturates, hypnotic, and tranquilizing drugs without prescription a disorderly person's offense. *Approval*

S-32 Ridolfi—To authorize the creation of professional service corporations. *Approval*

*S-36 Fox—To provide that no person, other than a pharmacist, shall sell any preparation or mixture or compound of drugs containing codeine or any barbiturate to any person under the age of 21, except upon a written prescription of a physician, dentist, or veterinarian. *Disapproval* . . . until recommendations for broadening the prohibition are included.

*S-53 Waddington—To require as a condition precedent to a person's obtaining a motor vehicle license that such applicant consent to take breath or blood tests in suspected drunken driving cases. *Approval*

*S-61 Connery—To permit an injured employee to select the physician he wishes to treat him under Workmen's Compensation Act. *Approval.*

S-120 Stout—To include "chiropractic physicians" under the law regulating chiropractors. *Active Opposition* . . . because it would give a title to chiropractors to which they have no proper claim; and would constitute an unwarranted extension of the practice of chiropractic.

S-123 Farley—To clarify the eligibility of certain dentists in relation to medical service plans. *Approval*

*S-142 Stout—To provide that services performed by a duly registered bioanalytical laboratory are within the scope of medical service plans. *No Action*

S-151 Fox—Companion bill to S-120. To define the practice of chiropractic as a "system of adjusting the articulations of the spinal column and related tissue by manipulation thereof." *Active Opposition* . . . because it is an unwarranted extension of the scope of the practice of chiropractic, and would give responsibility and privilege in areas for which chiropractors are not competent.

S-195 Hillery—To revise certain qualifications for persons to be admitted to examination for license to practice medicine and surgery. *Disapproval, with Active Opposition if moved* . . . because it would circumvent the lawful procedure for the licensing of a physician adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. Thus it is contrary to the public interest and unfair to all those physicians who are legitimately and properly licensed by the State of New Jersey through the functions of the Board of Medical Examiners.

*S-201 Ridolfi—To amend the Medical Practice Act to permit medical and x-ray technicians to perform certain technical ancillary services to licensed physicians. (Society sponsored) *Active Support*

*S-204 Ridolfi, Deamer—To authorize school medical inspectors to accept evidence of a satisfactorily performed examination by the family physician in lieu of the required school examination. (Society sponsored) *Active Support*

S-211 Fox, Dumont—To provide for the examination, certification, and regulation of psychologists by a State Board of Psychological Examiners. *Disapproval, with Active Opposition if moved* . . . because it invades the Medical Practice Act and assigns to unqualified lay-individuals functions which they are not licensed or qualified to fulfill by permitting them to practice "psychotherapy."

*SCR-2 Dumont—To reconstitute and continue the legislative commission to investigate the administration and rate schedule of the Hospital Service Plan of New Jersey. *No Action*

A-13 Hiering, Maraziti—To prohibit the discharge of pollutant matter or materials into coastal waters from any vessel afloat on said waters. *Approval*

*A-27 Sarcone, Higgins, Rimm, Smith—Identical with S-12 and A-353. *Active Support*

*A-40 Smith, Rimm—To provide for definitions of and standards for frozen dietary food. *Approval*

*A-99 Hughes—To change the definition of "narcotic drugs" to provide a more effective basis for the prevention of illegal use of narcotics. *Approval*

*A-102 Brady, Kijewski—To provide for state reimbursement to counties for the cost of the maintenance of county institutions for the medical treatment of alcoholics. *No Action*

A-103 Brady—To define "resident" of a boarding home for sheltered care and permit standards to be fixed by the State Board of Control of the Department of Institutions and Agencies, upon recommendation by the Hospital Licensing Board. *No Action*

*A-113 Stamler—To provide that certain notices of hospital and medical liens may be filed in the county clerk's office within 90 days after the first day of treatment. *Approval*

*A-120 Doren, Brigiani, Hughes—To make any person who steals narcotics or breaks or enters any enclosure, any store room, ship, airplane, with intent to steal narcotics, guilty of a high misdemeanor. *Approval*

A-174 Brady, Kijewski—To provide for the registering of dental laboratory operators and assistants by the State Board of Registration and Examination in dentistry. *Disapproval* . . . in support of the position of the New Jersey State Dental Society which contends that the bill is loosely drawn.

*A-176 Meloni, Werner, Yost, Bigley—To amend the act regulating Nursing; reduces age for professional nurse candidates from 20 to 18 years; raises fees for exams and registration. *Approval*

*A-187 Brady, Kijewski, Lynch, Meloni, Sweeney, Vohdin—To establish procedure for Banking and Insurance Commissioner to disapprove rates of medical service corporations and for court review thereof. *Active Opposition* . . . because it would empower the Commissioner of Banking and Insurance to fix fees to be paid by MSP to participating physicians and would therefore constitute an unwarranted and unjustifiable denial of the fundamental right of the physician to set his own fee for professional services rendered, thus threatening the operation of the Plan, in disregard of the best interests of the approximately two million people of New Jersey who are its subscribers.

*A-203 Brady, Kijewski, Lynch, Sweeney, Meloni, Vohdin—Identical with S-61. *Approval*

*A-240—Musto—Identical with S-53. *Approval.*

A-246 Hauser—To amend the procedure for granting religious exemptions from school immunization requirements. *Active Opposition* . . . because, in view of the recent outbreak of smallpox in England and other countries of Europe, legislation to excuse a teacher or pupil from the obligation of being vaccinated against smallpox is untimely and dangerous to the public welfare.

*A-289 Sarcone—Identical with S-36. *Disapproval* . . . until recommendations for broadening the prohibition are included.

*A-292 Sarcone—To limit the time for bringing actions at law by parents or guardians on behalf of minors under the age of 21 derived by reason of an injury to such minor. *Approval*

*A-293 Sarcone—Identical with S-27. *Approval*

*A-321 Hauser—To allow any legally incorporated humane society to enforce certain of the provisions of the laws relating to cruelty to animals. *Disapproval* . . . because existing laws which delegate this power to the New Jersey SPCA are adequate.

A-340 Kay—To prohibit the discharge of pollutant matter or materials into inland tidal waters and to regulate the operation of toilet facilities in vessels in said waters. *Approval*

*A-353 Werner, Meloni, Hughes, Bigley, Yost, Wilson—Identical with S-12 and A-27. *Active Support*

*A-383 Hughes, Kordja, Higgins—To regulate the practice of physical therapy or physiotherapy. *Active Opposition* . . . because it is unnecessary and undesirable, since the whole purpose of this legislation—to give proper function under proper control—would be accomplished by simple amendment of the Medical Practice Act.

*A-393 Brady—To make the requirement that containers shall be marked with the date of pasteurization applicable to cream. *Disapproval* . . . in conformity with the opinion of the U. S. Department of Health, Education, and Welfare that "the disadvantages are more significant than any advantages that may now be claimed for the dating of pasteurized milk" and in support of the contention of the Department of Health that the bill is not warranted or necessary.

*A-398 Hughes, Krueger, McGowan, Kordja—To provide that data in possession of the State Department of Health, pertaining to the health of any named person, procured in connection with research studies, approved by the Public Health Council, for the purpose of reducing the morbidity or mortality from any cause or condition of health shall be kept in confidence by the

Department except to persons participating in research study or in such impersonal form that the individual concerned cannot be identified. *Approval*

*A-402; — *A-404; — *A-405 Werner—Companion measures, to establish presumption by statute in certain illnesses of firemen and policemen. *Disapproval . . .* because they involve diagnosis by legislative enactment rather than by medical investigation.

*A-427 Bressler, Werner, Kijewski, Biber, Sweeney, —To oblige the State Board of Medical Examiners to make available for free distribution copies of all examination questions. *Disapproval . . .* in support of the position of the State Board of Medical Examiners, because these questions are freely available in the reference files of the State Library and compilations of Board questions are purchasable. It would be discriminatory against the taxpayers to adopt special legislation to provide copies of these examinations at the general expense to accommodate those interested.

*A-481 Werner, Koenig, Barbour, Yost—To permit suspension or revocation of medical license where the holder has been guilty of willful or gross malpractice or negligence endangering life. *Approval*

*A-493 Werner, Hughes—To reorganize the administration of public welfare functions within the Department of Institutions and Agencies. *No Action*

A-534 Hughes—To protect licensed physicians who in good faith render emergency first aid or care at the scene of the emergency from civil acts or omissions in rendering such care. "Good Samaritan Act." *Approval*

A draft of similar legislation was approved by the Council on April 12, 1961, to cover *all* persons who rendered emergency care at the scene of an accident or emergency. This measure would relate only tho those persons licensed under the Medical Practice Act.

*A-559 Werner—To require the use of humane methods in the slaughter of livestock. *No Action*

*ACR-45 Lynch—To memoralize Congress to enact legislation providing for payment of hospital services, skilled nursing home services, and home health services furnished to aged beneficiaries under the old-age, survivors and disability insurance programs. *Disapproval . . .* because it is economically unsound, politically unwise, and socially unjust to call upon the general citizens to provide and pay for services which individual citizens are capable of providing and paying for themselves. It is the contention of MSNJ that only needed services which individuals and their families cannot provide or pay for should be made available through tax-supported programs.

*AJR-3 Koenig, Barbour—To declare April as "Cancer Control Month." *No Action*

As soon as the foregoing positions were made official by the Board of Trustees, this information was transmitted—in four separate Legislative Bulletins to all New Jersey legislators, keymen, county secretaries and executive secretaries, cooperating agencies, and interested individuals. During the 1961 session, ten such separate bulletins were sent out.

NATIONAL LEGISLATION

In cooperation with the American Medical Association and other organizations opposing the adoption of legislation (such as HR 4222 —the King-Anderson bill) to enlarge social security benefits to provide health care services for all social security beneficiaries regardless of their own ability to provide such services themselves, under the sponsorship of the Council, The Medical Society of New Jersey carried on a concentrated campaign for five consecutive weeks, "Operation Contact," which began January 28.

The purpose of "Operation Contact" was to stimulate letters from constituents to their New Jersey congressmen and senators in opposition to this—or any similar—legislation. Invited to the Executive Offices in early January to launch this campaign were 146 selected representatives of MSNJ and its Auxiliary, comprising the "Task Force." Each member of the "Task Force" made himself or herself responsible for getting ten people each week, for the five consecutive weeks, to send letters to their congressmen and senators opposing legislation of this type. Each member also got one other member of his or her community to work as a partner in this effort, who also were to get ten people to write each week for the time stipulated. These two people working together, as partners, were expected in five weeks of the campaign to get a total of 100 letters to the congressmen from their district from fellow-citizens whom they contacted.

To assist in presenting adequate reasons to win people to Medicine's point of view, copies of selected materials were supplied—including the Council's own pamphlet, "A Free America or a Welfare State?"—prepared in conjunction with the Council on Public Relations. Thus far, approximately 25,000 copies of this pamphlet alone have been distributed.

The success of this campaign is reflected in the many favorable comments, communications, and requests for additional materials received from lay-citizens that continue to come to the Executive Offices. The Council is particularly grateful to those members of the

Woman's Auxiliary who so actively and effectively participated in this campaign.

In addition, two special *Periodic Newsletters* were sent out to cooperating agencies and to all members of MSNJ and its Woman's Auxiliary, alerting them as citizens to the fact that Congress is being strenuously pressured in the 1962 session to pass the King-Anderson Bill (HR 4222)—or some similar measure—and to warn that adoption of legislation of this character would constitute an irrevocable and irreversible step toward the abandonment of a free America and the substitution instead of a welfare state.

Approved (page 445)

Supplemental Report

Since the compilation of the annual report submitted to this House, the following official positions have been taken with reference to legislation recently introduced:

S-228 *Bowkley*—To require the registration of physical therapists with the State Board of Medical Examiners. *Approval*

S-234 *Waddington*—To require as a condition precedent to a person's obtaining a motor vehicle license that such applicant consent to take breath or blood tests in suspected drunken driving cases. (Identical with S-53 of 1962) *Approval*

S-261 *Dumont, Waddington*—To permit medical service corporations to issue master group contracts to employees and other policy holders. *Approval*

S-262 *Dumont, Waddington*—To permit medical service corporations to provide group contracts covering at least 100 employees or members based upon experience rated premiums and to levy an annual supervisory fee of $20,000 on such corporations. *Approval*

S-263 *Dumont, Waddington*—To allow medical service corporations to enter into agreements with other corporations to underwrite group contracts covering employees outside the State. *Approval*

S-264 *Dumont, Waddington*—To give the Commissioner of Banking and Insurance authority to disapprove practices, rules, and procedures of a medical service corporation where he feels they are unjust, unfair, or inequitable. *Active Opposition* . . . because, in contravention of the public interest, this measure would unwarrantedly grant the Commissioner dictatorial powers that would invade and usurp the normal functions and discretion of the board of trustees of a medical service corporation and would thus threaten the continuance of operation of such medical corporation in this State.

Position approved (page 445)

S-265 *Dumont, Waddington*—To permit a medical service corporation to file and enforce a lien when it has made payment to a physician for services rendered and to provide for the reimbursement of the medical service corporation by the physician in the event the lien is paid. *Approval*

S-266 *Dumont, Waddington*—To authorize medical service corporations to include in their contracts a subrogation provision in the event a subscriber or eligible dependent receives payments for injuries resulting from the negligence or wrongdoing of a third party. *Approval*

A-602 *Lynch, Brady, Kijewski*—To amend the law governing medical services corporations to eliminate requirements that a corporate trust shall be approved by a recognized medical society and that 51 per cent of the licensed physicians in any county must participate before the corporation may transact business therein. *Disapproval with Active Opposition if moved* . . . because, it would eliminate the requirements originally insisted upon by the State Commissioner of Banking and Insurance which serve as a guarantee of the quality and adequacy of available medical care for subscribers under the contemplated plans.

A-677 *McGowan, Sarcone, Meloni*—(Identical with S-263 of 1962) *Approval*

A-678 *McGowan, Sarcone, Meloni*—(Identical with S-264 of 1962) *Active Opposition*

Position approved (page 445)

A-684 *McGowan, Sarcone, Meloni*—(Identical with S-262 of 1962) *Approval*

A-685 *Sarcone, McGowan, Meloni*—(Identical with S-266 of 1962) *Approval*

A-686 *Sarcone, McGowan, Meloni*—(Identical with S-265 of 1962) *Approval*

A-287 *Sarcone, McGowan, Meloni*—(Identical with S-261 of 1962) *Approval*

At the session on May 7, as was reported in the information media, Assemblymen Kijewski, Brady, Lynch, Werner, Sweeney, Bressler, and Musto introduced A-755—to forbid licensed medical practitioners to refuse their services to a person solely because of the prospective or intended method for payment of the charge for such service.

On May 9, President Buchanan sent through the Executive Offices the following message to the members of the New Jersey State Legislature in opposition to A-755:

> As President of The Medical Society of New Jersey, in behalf of its approximately 7,100 member-physicians, I protest against A-755 as a measure which grossly discriminates against the members of the medical profession and invades and

disregards their constitutional rights as free men and American citizens to determine on what terms they shall dispense their professional services.

In the unavailability of A-755 for study and detailed evaluation, it is in contravention of due legislative process and of fair play that the measure has been advanced toward ultimate disposition.

A physician is a free American, who has voluntarily—and at his own expense of time, money, and energy—chosen to make his livelihood by practicing medicine and surgery. He was not sentenced to do so. He is not in the public employ. As a private citizen, offering to use his skills in behalf of patients who seek his services and whom he accepts, he is no more compelled—by justice or morality—to render professional services to all and any who levy demands upon him than people at large are compelled to submit themselves to him. The physician engages, on the basis of terms agreed upon, to render a service. The patient accepts the terms for that service, and a mutually binding contract is freely entered into. Freedom on the part of both parties is essential to the validity of that contract.

The physician is not a slave; he is a free man and—regularly!—a gifted, industrious, capable, kind, and conscientious man. He is no more bound to indiscriminate service—at the demand of government or citizens—than is the lawyer, the dentist, the pharmacist, the nurse, the engineer, or the member of any other profession or trade.

His license grants him the privilege of professional practice, recognizing him as well qualified. It does not condemn him to practice. He can practice or not, as he wishes—as long or as little as he likes. If this were not so, no intelligent American would want to hold a license as a physician, since it would mean the surrender of his liberty.

I have not yet seen this legislation, but I do not hestitate to say that if it is intended to compel the physician licensed by New Jersey to serve, without choice, all who make demands upon him and to forego the right of disposing of his services on terms acceptable to him, then all members of the medical profession—and all citizens who value and will fight for individual liberty—will oppose it.

I have every confidence that the New Jersey Legislature will be true to its intelligence and to its duty as an American law-making body, and that after full and proper study and discussion it will give this ill-considered, unfair, and discriminating piece of legislative tyranny the wholehearted condemnation which it deserves.

There are currently on the Council's agenda, awaiting its next meeting, approximately forty measures which must be dealt with. These have been introduced in the New Jersey Legislature within the past few weeks.

According to reports in the local press, the New Jersey Legislature will adjourn the present session at the close of the May 14 meeting until Fall.

Approved (page 445)

MEDICAL SERVICES

Irving Klompus, M.D., Chairman, Bound Brook

(Reference Committee "F")

The Council on Medical Services met twice during the year and studied:

1) Blue Cross outpatient service allowance.

2) Recruitment of patients by a hospital for diagnosis under the provision of Rider J.

3) Change in the medical system of a prominent New Jersey hospital.

4) Question regarding availability of a patient's record to a Union was discussed.

These problems were referred to the Board of Trustees after deliberation and, in all cases, the Board agreed with the action of the Council on Medical Services and took appropriate action.

The Relative Value Index has been discussed and the following actions were taken:

1) Publicity in the form of articles in THE JOURNAL.

2) Publicity in local county journals.

3) A mail poll of the membership's wishes in this matter was authorized by the Board of Trustees. It is hoped that the result of the mail poll will be available for the guidance of the House of Delegates at the time of the annual meeting.

Approved (page 448)

Recommendation of reference committee adopted: That the threat of the corporate practice of medicine by hospitals be vigilantly and diligently met with.

PUBLIC HEALTH

John B. Fuhrmann, M.D., Chairman, Flemington

(Reference Committee "G")

The ruling of the Board of Trustees that all special committees of the council shall meet at least two weeks before the council meetings has brought good results. Almost every special committee met in accordance with this ruling, except where weather prevented meetings. This expedited the work of the council, as we were able to consider only the recommendations of the special committees after having copies of their minutes in our hands prior to our meeting. By continuing this orderly organization of special committee meetings during the coming years, it will again be possible to limit meetings of the council to two hours, thereby making it possible to have better attendance at the meetings and to make definite progress with the general program of the council.

It has been the feeling of your chairman and some members of the Council that problems dealing with the general public health of the State should be undertaken by the Council and to this end we have tried this year to activate some projects as follows:

1) The establishment of a subcommittee on Air Pollution, to give technical advice to the Commission on Air Pollution of the New Jersey State Department of Health.

2) The co-sponsoring of a seminar with the New Jersey Veterinary Medical Association, to probe problems which are common to the two organizations.

3) Establishment of liaison with the State Department of Health, to encourage the development of a statewide program to aid in the reduction of pollution of beach and shore waters. This is being done in coordination with the Council on Legislation.

The close cooperation that we have received from Doctor Roscoe P. Kandle, State Commissioner of Health, during the past year demands special consideration and recognition. Last year he was invited to sit in as a consultant and accepted. This year he has continued in this capacity and has been an invaluable aid to us in many fields including:

1) Pollution of Beach and Shore Waters.
2. Tuberculosis Testing in Schools.
3) Polio Immunization.
4) Medic Alert.

A unique problem was presented to us when the organization of "Medic Alert" asked us for endorsement. After investigation, it was determined that the AMA had recently established a Committee on Emergency Medical Identification to investigate thoroughly this problem and make recommendations that could be nationally adopted. Therefore, any action by our Council is waiting reports from this committee.

Notable progress has been made by our special committees during the past year. Several projects are worthy of mention at this time:

1) Continued progress with statewide establishment of cancer registries in general hospitals.

2) Investigation of the possibility of establishment of privileged communications for the physicians of New Jersey.

3) Adoption of Standard Hospital Forms as recommended by the AMA Committee on Maternal and Child Care, together with the adoption of the Apgar Rating.

4) Adoption of "An Eye Health and Eye Screening Program for Schools," to be advocated for all public, private, and parochial schools throughout the State.

5) Investigation of various methods of Tuberculin testing.

This is only a partial list. For more complete details your attention is directed to the special committee reports. However, it is obvious that our committees are working well under competent chairmen and are delving into many fields of public health.

Approved (page 449)

PUBLIC RELATIONS

John F. Kustrup, M.D., Chairman, Trenton

(Reference Committee "E")

Meeting in regular full session twice this year, the Council on Public Relations supervised the following continuing and special projects and activities which it routinely administers:

Junior Health Hints (Series Three—1961-62) . . . published and distributed to approximately 2,800 teaching personnel at junior and senior high school level. The Council also revised and brought up to date its *Junior Health Hint* mailing list to insure that all copies mailed are actively used.

Health Hints . . . published and distributed 28 separate releases to daily and weekly newspapers, house organs, and others—resulting in approximately 1,076 separate articles (including 13 editorials). The Council also revised this mailing list, and reduced the total mailing without a resultant decrease in the number of published articles.

Membership News Letter . . . published and distributed 9 separate issues. At its reorganization meeting, the Council reaffirmed its opinion that this publication regularly brings to the members those data of day-by-day information essential to their understanding of the policies of the Society and the considerations which govern them in their daily lives and practices.

For this reason, the Council will each year —starting June 1962—send to each component society for retention in the official files, bound and indexed, a compilation of the year's *Membership* and *Periodic Newsletters.*

Periodic Newsletter . . . in cooperation with the Council on Legislation, published and distributed two special issues on national legislation to cooperating agencies and individuals, and to members of MSNJ and its Woman's Auxiliary.

Special News Releases . . . in furtherance of the Society's business and interests, issued fifteen separate releases in support of:

1) 1961 Annual Meeting: 2-page general announcement; 1-page biographical sketch, with pictures, of incoming president; 1-page biographical sketch of retiring president; 4-page release announcing Golden Merit Award recipients; 9-page release of president's inaugural address; several miscellaneous, general news items, as requested, from Atlantic City;

2) Judicial Council's opinion concerning professional association of members of MSNJ with all other fully licensed physicians and surgeons of New Jersey—2 pages;

3) 1961 Eye Health Screening Program, under the sponsorship of the Special Committee on the Conservation of Vision—10 pages;

4) MSNJ's official statement at the public hearing before the United States Senate Subcommittee on Aging—6 pages;

5) Child Safety Symposium, under the sponsorship of the Special Committee on Child Health—1 page;

6) Child Safety Week, under the sponsorship of the Special Committee on Child Health—5 separate health hints; a special spot announcement release was also sent to all radio stations in New Jersey.

Golden Merit Award . . . supervised the 1961 Award, which had 27 recipients—17 of whom attended the ceremonies in Atlantic City. There are 35 candidates eligible to receive the 1962 Award.

Press Clipping Service . . . re-evaluated this service—in light of its increasing cost—and agreed that it should be maintained, in the interest of serving various activities and departments of MSNJ, among which are: Woman's Auxiliary, THE JOURNAL, membership, directory, etc.

GPR Means GPR . . . distributed to the entire membership—through component societies —in bulk supply, as requested, copies of the pamphlet distributed at the 195th Annual Meeting PR exhibit, "Good Public Relations Means Genuine Personal Responsibility."

BYLAW AMENDMENT

At its reorganization meeting, the Council was unanimous in its opinion that the poor attendance at MSNJ council and committee

meetings necessitated serious consideration of methods to improve the situation. It therefore recommended the following Bylaw revision—which will come before the House of Delegates:

> If a member of a council or committee—either appointed by the president or elected by the House of Delegates—absents himself from two consecutive meetings without excuse, he may be presumed to have vacated his position on the council or committee, and the president may fill the vacancy pro tem.

MEDICAL STUDENT LOAN FUND

In the interest of increasing donations to the Fund, the Council devised—in conjunction with the committee—and underwrote the cost of new forms to be used by component societies in soliciting "donations to commemorate the dead" and "donations to honor the living."

MEMBERSHIP DECALS

The Council was informed that members' cars have been refused inspection because of the placement of decals—despite the assurance received in 1960 from the Division of Motor Vehicles that it was permissible to "display the decal on either the rear window or the rear side window."

The Council recommended, and the Board approved, that through the Society's liaison committee with the Division of Motor Vehicles (1) the decals be honored in the interest of recognizing an M.D. in an official emergency situation; (2) the Division make official declaration concerning the placement of decals and thus inform all inspection stations in New Jersey; (3) the Division record "M.D." on the driver's license card of physician-members.

WOMAN'S AUXILIARY HEALTH CAREER BOOKLET

The Council underwrote the cost of printing (up to $250) a "Guide to Health Careers in New Jersey in the Medical and Paramedical Fields," compiled by the Auxiliary and planned for distribution by them in New Jersey to junior and senior high schools and colleges.

PAMPHLET ON LEGISLATION

The Council prepared and distributed—in cooperation with the Council on Legislation—a pamphlet entitled, "A Free America or a Welfare State?" The demand for this pamphlet necessitated three printings of ten thousand each.

TELEPHONE DIRECTORY LISTINGS

In the interest of uniformity—since disagreement among component societies concerning this matter, in the Council's view, makes for disunity and misunderstanding—the Council recommended, and the Board of Trustees approved, that component societies be requested to permit the listing of specialties and office hours in ordinary lettering in the Yellow Pages of the local telephone directory, but that they prohibit the use of of bold-face type for such listings.

ANNUAL MEETING PRESS COVERAGE

In conformity with established policy, the Council will sponsor a press room at the 196th Annual Meeting. It will be located in the Card Room, Lobby Floor of Haddon Hall. Advance press releases will be mailed from the Executive Offices. Through the press room in Atlantic City, information will be given to the press representatives, interviews will be arranged, and publicity pictures scheduled. Miscellaneous and spot releases will be issued as indicated.

Approved (page 446)

Special Committees to the Administrative Council on Medical Services • • •

INDUSTRIAL HEALTH

Delma W. Caldwell, M.D., Chairman, Linden

(Reference Committee "F")

PROJECTS CARRIED OVER FROM 1960-61

1) To emphasize the need for tetanus toxoid immunization in occupations and to stimulate aid and interest of physicians in this program.

2) To explore the possibilities of presenting an occupational health program at the 1962 annual meeting—program to include both a panel discussion and exhibit.

3) To study the possibility of publishing a pamphlet on organization and operation of an industrial health program for distribution in New Jersey, as has been done in Ohio.

NEW PROJECTS INCLUDED IN THE 1961-62 EFFORT

1) Effort to include on the Governor's Advisory Committee on the Health and Safety of Workers a member of The Medical Society of New Jersey.

2) Participation in the Congress on Occupational Health sponsored by the American Medical Association.

3) Joint meeting with the Special Committee on Workmen's Compensation.

4) Review and comment to the Board of Trustees of The Medical Society of New Jersey on the proposed new law "Worker Health and Safety Act," prepared by the Governor's Advisory Committee on the Health and Safety of Workers.

5) Review of AMA Council on Occupational Health publications on orthopedic, cardiac, eye, etc., physical-work evaluation.

PROJECTS COMPLETED OR IN THE PROCESS OF COMPLETION

1) The tetanus immunization project carried over from the prior year was completed by having published, in THE JOURNAL of The Medical Society of New Jersey, an appeal to physicians to survey and carry out such an immunization program.

2) It was decided to have an exhibit on small plant medical services and emergency treatment kits for the annual meeting in Atlantic City. The exhibit will consist of a wall display of cards showing, in an organization form, medical services available under varying conditions of small plants. Beneath the exhibit, on a display table, will be a series of emergency treatment kits (plastic containers) with proper indications and directions for use attached to each kit. This idea and the component parts are being supplied by Dr. Willis Mitchell, a member of this committee. It is hoped that a third part of the exhibit will be the display of toxicology and emergency treatment texts, loaned by publishers accepted as experts by the Society.

3) A detailed report on the attendance by the chairman of this committee at the AMA Congress on Occupational Health in Denver in October was presented to the Board of Trustees on October 20, 1961. On November 29, 1961, the Secretary of the Board of Trustees notified the committee of the "No Action" and "Approvals" on the nine items reported to the Board of Trustees.

4) A joint meeting with the Workmen's Compensation Committee was accomplished. With so many interests in common, it was agreed by all who attended the joint meeting that such a combined meeting should be held at least once—and perhaps twice—a year.

5) A critique in written form was submitted to the Board of Trustees on the review of the final draft of the "Worker Health and Safety Act."

AREAS FOR FUTURE DEVELOPMENT

1) Preparation of articles of mutual interest (general rather than specific) to occupational and non-occupational physicians for MSNJ JOURNAL.

2) Completion of a pamphlet on organization and operation of various types of industrial health programs for distribution in New Jersey.

3) Marked emphasis on putting into action the previously suggested idea that the committee should offer to the component societies the services of the committee members in having them appear before county society meetings and talking on the subjects dealt with by the committee. This might aid in supplementing the articles to be published in THE JOURNAL.

4) The committee feels that a future area of development is in assisting component societies in industrial matters brought to their attention at local level.

5) In conjunction with other select committees of the State Society, much study needs to be given to the very acute and rapidly growing problem of "free choice of physician."

Approved (page 448)

WORKMEN'S COMPENSATION

Joseph A. Lepree, M.D., Chairman, Elizabeth

(Reference Committee "F")

The Special Committee on Workmen's Compensation has continued its study of "Medical Rating of Physical Impairment" and the "Guides to the Evaluation of Permanent Impairment" developed by the AMA through its Committee on Medical Rating of Physical Impairment. A large amount of the committee's activities has centered upon the AMA Cardiac Impairment Guides. The Special Committees on Workmen's Compensation and Industrial Health will meet jointly, at an opportune time in the future, with a committee from the New Jersey State Bar Association to explore the meaning and definition of physical disability as applied to physical impairment, as to what the doctor's task is in determining impairment and disability, whether it is possible to divide these two and put disability in the hands of people who understand job evaluation as opposed to physical impairment, so that it may be possible then to equate physical impairment with physical disability on the same logical basis.

The committee also studied a report from the AMA Congress on Occupational Health dealing with free choice of physician and definition of impairment and disability.

The committee is studying the matter of a fee schedule for use in workmen's compensation cases involving state employees, referred by the Board of Trustees. The committee is authorized to confer with the Chief of the Claims Bureau of the State Department of Law and Public Safety concerning questionable items, and such a meeting will be arranged in the near future.

The Special Committee on Workmen's Compensation will continue to study and review the AMA "Guides to the Evaluation of Permanent Impairment" and the fee schedule for use in Workmen's Compensation Cases Involving State Employees.

Approved (page 448)

Special Committees to the Administrative Council on Public Health • • •

CANCER CONTROL

John L. Olpp, M.D., Chairman, Englewood

(Reference Committee "G")

A survey of 98 New Jersey Hospitals elicited the following information:

Hospitals with Tumor Registry	66
Hospitals with no Tumor Registry but with a Cancer Committee	12
Hospitals with no Tumor Registry or Cancer Committee	21

The 66 hospitals with Tumor Registries were surveyed for the forms utilized, with the following results:

Cancer Registry Abstract Form	51
Info-Dex Cancer Registry System	10
Various other forms	5

It will be noted that the Cancer Registry Abstract Form is furnished to any hospital by the New Jersey Division of the American Cancer Society.

After discussing the mechanism for the operation of a central tumor registry, it was agreed that accurate abstraction of patients' charts is most important to the success of the Registry. It was further agreed that a Central Registry should be automated from the start.

RECOMMENDATIONS

1) That training of personnel for cancer registries in individual hospitals be encouraged and supervised by the State Department of Health.

2) That a consultant on cancer registries be requested from the National Institute of Health to advise the committee on establishment and operation of a central registry.

The State Department of Health has been represented at every meeting of the Special Committee on Cancer Control. This liaison has been very helpful and gratifying to the members of the committee.

Approved **(page 449)**

Committee is encouraged to continue its efforts to have a tumor registry established in every hospital in the State.

CHILD HEALTH

Robert E. Jennings, M.D., Chairman, South Orange

(Reference Committee "G")

Two meetings of the Special Committee on Child Health were held during the year.

The committee feels that some closer tie should be established with the school physicians throughout the State. Ways and means of accomplishing this are yet to be worked out.

An educational exhibit—"Recognition and Treatment of Learning Disorders in Children"—dealing with school failures due to learning disabilities, will be presented by the committee at the annual meeting.

CHILD SAFETY SYMPOSIUM

The committee sponsored a Symposium on Child Safety, which was presented at the Nurses' Home, Presbyterian Hospital Unit, United Hospitals of Newark, on April 7, 1962. Members of the medical and allied social professions participated. In conjunction with the symposium, Governor Hughes proclaimed the week of April 1, 1962, as "Child Safety Week."

TB TESTS

An inquiry was presented to the committee concerning the relative merits of the Mantoux Test and the newly introduced Tine, Heaf, and Sternneedle tests. It was the opinion of the committee that the intradermal (Mantoux) test using PPD, properly administered, is still the method of choice. The committee approved a recommendation that the Heaf, Tine, and Sternneedle tests may be used where mass screening tests for tuberculosis are indicated when competent facilities for administering the Mantoux Test are not available.

FARM WORKERS

The committee considered the prob'em of the health of the children of migrant farm workers. The problems that exist seem to be primarily socio-economic. The committee suggests that the medical societies of counties where migrant farm workers are employed establish liaison with the Coordinator of the Maternal and Child Health Program of the State Department of Health, to determine in what spheres the component societies, through their members, may aid in the problems of children of the migrant workers.

MEETINGS

During the year, the chairman was privileged to represent the Medical Society at the Joint Meeting of the American Medical Association with the American School Health Association in New York City on "Health of School Personnel." He also represented the Society at a Symposium on Athletic Injuries sponsored by the Bergen County Medical Society.

Approved (page 449)

CHRONICALLY ILL AND THE AGING

William H. Hahn, M.D., Chairman, Newark

(Reference Committee "G")

The Committee on the Chronically Ill and the Aging met three times during 1961-62, including a meeting with the Joint Council to Improve the Health Care of the Aged. Our committee has concerned itself with the development of committees for the care of the chronically ill and the aging in each component society and the development of a program at county level by each component society, or by regional committees in those areas where the problem is not severe enough to warrant a committee in each county.

The committee feels that, in view of the great activity in many organizations concerned with the problems of the chronically ill and the aging, and because of the great needs and demands in this area, our Society should foster and implement a positive program of action which should include a formal presentation before the senior citizens.

COUNTY COMMITTEES

The committee feels that the program for the chronically ill and the aged can be best developed at the county level. The people there are more familiar with the local problems and better able to evolve adequate solutions. Each county society should organize a local committee which should be charged with the responsibility of organizing the program in its county by:

1) Contacting each agency in the area that is interested in the problem and calling a meet- of representatives of each of these agencies.

2) Making a survey to gather information on:
   a) the number of chronically ill and aging and their approximate needs, particularly in the area of health facilities;
   b) determining the extent of the facilities presently existing and what facilities

would be necessary to meet the needs as shown by survey.

It would develop an information and referral service for the use of interested people and agencies.

3) Stimulating the development of needed facilities by demonstrating the survey facts and figures to the interested health agencies and governmental agencies.
4) Encouraging the interest of voluntary workers and agencies in these problems.
5) Cooperating with hospitals, nursing homes, and home-care programs, by providing medical leadership in the development and maintenance of the programs that are developing for the care of the chronically ill and the aging in these institutions.

In past years our committee has attempted to stimulate the development of county committees. It has invited representatives of county committees to meetings at the State Society's headquarters. The committee believes that there are several effective programs for the chronically ill and the aging already in operation in several of our counties. We do not have accurate information as to the number of these organizations or the extent of their activities, nor have we been asked for help from any of them.

RECOMMENDATION

It is the recommendation of our committee that each component society establish a Committee on the Chronically Ill and the Aged charged with the responsibility of organizing a program as outlined above.

Approved (page 449)

STATE COMMITTEE

Our committee believes it can be of help in directing the county committees to sources of information as to what has been done elsewhere, to give advice and help in contacting the necessary agencies, in helping them to secure available voluntary or government aid in the support of the program and in aid of the patients.

We believe that separate and specific secretarial help for the committee would aid materially in developing and maintaining liaison with the various committees, and would effectuate positive participation of the medical profession in the health care of the chronically ill and the aged. The person assigned would devote a specified amount of time, as indicated by experience, to these problems by:

1) Regularly bringing notices to the county committees of the activities of the State Committee and of the Joint Council to Improve the Health Care of the Aged.
2) Obtaining information from each county society by telephone, by letter, or in person, as to what progress is being made in each county, and making this material available to all interested agencies.
3) Bringing to the attention of all committees the activities of all other agencies, with the hope of stimulating activity and membership in the various groups.
4) Keeping in contact with the various health agencies and enlisting their interest and support of the various county committees, and aiding in securing their cooperation in the program.
5) Aiding the development of a library concerned with the literature pertaining to the chronically ill and the aged and publicizing this to the various county committees.
6) Aiding each county committee to provide a panel of speakers who would make presentations before such groups as the Nursing Home Groups, Senior Citizens Groups, and others. These presentations would be oriented toward the medical care of the chronically ill and the aged. The State Committee will help in the organization of these bureaus and help secure speakers.

There is such an agency now in Essex County—the CHR-ILL Service (Essex County Service for the Chronically Ill) founded at the instigation of the Essex County Medical Society. It receives financial support from that county society and from other organizations interested in health—tuberculosis, heart, polio, crippled children and adults, various community chests, and various levels of government within the county. A paid Executive Secretary is in charge under the direction of a Board of Directors which includes at least 14 members of the Essex County Medical Society. The aid of many individuals and organizations has been enlisted through the activity of this office, and notable contributions have been made: Visiting Home-Maker Service, which has served as a model for organization throughout the country; development of the Alcoholism Committee; and securing the cooperation of visiting nurses in home-care programs. This organization has been helpful in aiding other organizations to develop and progress, and would give help in developing similar organizations in other areas of New Jersey.

RECOMMENDATION

That the State Society provide separate secretarial help for the Committee on the Chronically Ill and the Aged.

This recommendation was amended to read "to provide secretarial help when needed to give liaison between the state and county committees" and adopted by the Council on Public Health. However, the Board of Trustees at its April meeting tabled the recommendation.

Disapproved (page 449), because it is felt that there is considerable overlap between the activities of this committee and the Special Committee on Rehabilitation.

CONTINUING PROJECTS

The committee is studying available services for home nursing care, coordinated home care, and home care. Policies and principles for the guidance of the Home Care Program under medical supervision will be drafted by the committee in cooperation with the State Department of Health.

Next year the committee hopes to hold a state-wide meeting featuring speakers and exhibits portraying the activities of the State and county societies in the field of Health Care of the Chronically Ill and the Aging.

Approved (page 449), except for second recommendation.

Recommendation of reference committee adopted: That the activities of the Special Committees on the Chronically Ill and the Aging and on Rehabilitation be coordinated to avoid duplication of effort and cost toward establishing and maintaining a directory of rehabilitative services, and that the aid of the State Department of Health be enlisted to initiate and undertake this statewide project.

CONSERVATION OF HEARING AND SPEECH

James H. Spillane, M.D., Chairman, Phillipsburg

(Reference Committee "G")

The Special Committee on Conservation of Hearing and Speech has followed the progress of hearing and speech centers throughout the State, and plans to invite the chairmen of these centers to one of the regular fall meetings.

SCREENING FOR HEARING DEFECTS

A great deal of time has been devoted to the problem of screening the populace for hearing defects similar to the well-known "eye week." Many plans were reviewed, including the use of existing facilities as well as mobile units. It was felt that a practical approach would be a thorough study of the screening already performed. Once this information is made available, further work can be planned. As a part of this study, county superintendents of schools were contacted so that the committee would be thoroughly aware of just how much screening is already being performed in the school systems. Replies from most counties have been received and shortly this information should be compiled.

HEARING AIDS

The committee has further studied the codes of ethics of hearing aid dealers and salesmen. Your chairman attended a portion of the SHAA Annual Convention in Chicago. This committee is making no recommendations on this subject this year.

EXHIBIT

The committee has planned an education exhibit for the annual convention entitled "Detection and Classification of Hearing Loss"—Booth E-103.

Approved (page 449)

CONSERVATION OF VISION

Samuel M. Diskan, M.D., Chairman, Atlantic City

(Reference Committee "G")

The Special Committee on Conservation of Vision continued several projects from previous years and instituted two new projects.

EYE HEALTH SCREENING PROGRAM

This year for the fifth consecutive year, The Medical Society of New Jersey, under the auspices of the Special Committee on Conservation of Vision, conducted a statewide Eye Health Screening Program. The program was aided and supported by the New Jersey Academy of Ophthalmology and Otolaryngology, the New Jersey State Commission for the Blind, and the New Jersey Hospital Association, but it could not have been possible without the invaluable assistance of the Executive Office staff and the support of the Council on Public Relations.

The program was conducted in the last week of September in 1961 and was manned by approximately 180 ophthalmologists. 7,426 persons were screened. This is 35 per cent more than during 1960 and the largest number ever tested. 46.2 per cent of these tested were found to need corrective eye care. This program is probably one of our better public relations and eye health projects and should be offered to the public next year with several innovations suggested by the committee to expand the size of the program.

New Jersey physicians are urged to support this project and encourage their patients to attend the screening program scheduled in their area.

RECOMMENDATION

That the House of Delegates approve the continuation of this program scheduled for the week of September 24, 1962.

Approved (page 449)

SCHOOL EYE HEALTH PROGRAM

A great deal of time was spent by the committee with the object of presenting a uniform Eye Health Program that could be effectively used in the schools of New Jersey.

The ophthalmologists of New Jersey were circularized to determine the availability of ophthalmic manpower to carry out this project. One hundred, fifteen ophthalmologists in New Jersey indicated their willingness to participate in the school eye care program. Meetings were held in conjunction with Doctor Geoffrey W. Esty, representing the New Jersey State Department of Education. The committee prepared a booklet, "An Eye Health and Eye Screening Program for Schools," as the standard text for the development of this program. The next step will be the dissemination of this report and the scheduling of workshops on "Eye Care for School Children," throughout the State, to implement the program.

RECOMMENDATION

That the School Eye Care Program be approved as presented for continued action by the committee next year.

Approved (page 449)

Ophthalmologists should be encouraged to schedule workshops on "Eye Care for School Children" (page 449).

CONTACT LENSES

The opinion of the Attorney General in regard to the contact lens question was somewhat contradictory, in that it pointed out that several procedures required for the correct practice of fitting contact lenses was proscribed to optometrists, yet it indicated that the law as written did not prohibit optometrists from pre-

scribing contact lenses. The committee requested that the Society's legal counsel study this opinion. The committee felt that to understand the contact lens problem there must be a recognition of the difference between the "practice of" or the "prescribing of contact lenses," which is purely a medical decision; and the "fitting of" or the "application of the lens to the eye," which is not much more than the patient does when the lens is applied to the eye. This is not a medical act.

RECOMMENDATION

That the committee, in the interest of the public welfare at large, continue to investigate the contact lens problems.

Approved (page 449)

EYE BANK FACILITIES

The committee endorsed a request for action from Commissioner Kandle concerning a need to change the law which presently allows heirs to negate the request of a deceased who has willed his eyes to an Eye Bank. This change of law will improve availability of eye specimens for use in New Jersey.

EYE HEALTH INFORMATION

The committee recommends that physicians disseminate to their patients the U. S. Department of Health, Education and Welfare booklet, Health Information Series No. 64, titled, "Care of the Eyes." It is an excellent informative booklet that every patient should read.

Approved (page 449)

MATERNAL AND INFANT WELFARE

John D. Preece, M.D., Chairman, Trenton

(Reference Committee "G")

The Special Committee on Maternal and Infant Welfare is continuing its work of collecting and classifying the maternal death reports throughout the State, in cooperation with the Division of Maternal and Infant Welfare of the New Jersey State Department of Health.

The quality and number of reports received in 1961 were the most complete that we have received in the past ten years.

The committee, in 1962-63, will work for an increased efficiency along this line and encourage the hospitals of the State to cooperate by using the special History Forms suggested by the AMA.

It is the opinion of the special committee that in some areas maternal deaths are not being reported because they occur in connection with patients who are re-admitted to hospitals for some condition following delivery. Therefore, the Board of Trustees approved the committee's recommendation that the State Department of Health be requested to notify responsible agents in each hospital that all deaths following a recent pregnancy (up to six weeks) be reported as maternal deaths and special notation be made on the death certificate as to date of delivery; and that an item be published in THE JOURNAL and/or the *Membership News Letter* to bring this recommendation to the attention of all members.

Approved (page 449)

MENTAL HEALTH

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "G")

This committee worked diligently in support of A-649 (1961 Mental Health Act) and was disappointed that it failed to pass in the 1961 legislature. We recommend that The Medical Society of New Jersey exert all possible effort to urge re-introduction of A-649 (1961 Mental Health Act) into the 1962 legislature.

PRIVILEGED COMMUNICATIONS

The committee has discussed at each of its meetings the matter of confidentiality and privileged communication, having been encouraged by the success of other state medical societies in obtaining effectuating legislation. Efforts to stimulate statewide interest continue in the hopes that some conference can be arranged in order to expedite an administration bill which would accomplish a privileged communication act for all New Jersey physicians.

Recommendation of reference committee adopted: That the efforts of this committee to stimulate statewide interest in a privileged communication act be continued.

ACTION FOR MENTAL HEALTH

This committee has continued to study the Joint Commission on Mental Health report, titled "Action for Mental Health," and although not totally in support of all recommendations, nevertheless felt that this monumental piece of work deserved our continued support in the hopes of implementing the constructive measures offered by the Joint Commission.

AMA MEETING

The chairman was privileged to attend the Eighth Annual AMA Conference on Mental Health in Chicago on February 2-3, which served as the planning committee for the implementation of the First AMA Congress on Mental Health to be held in Chicago on October 5-7. The committee is desirous and hopeful that the Medical Society and all of its affiliated organizations will be properly represented at this National Congress because of the tremendous service it can render in regard to the mental health of the nation.

PSYCHOLOGY BILL

The committee reiterated the stand of its predecessors in opposing a bill to effect the certification of psychologists because of the bill's failure to provide an accurate definition of the scope of practice of the individuals involved in the legislation.

Approved (page 449)

REHABILITATION

Elmer J. Elias, M.D., Chairman, Trenton

(Reference Committee "G")

The Special Committee on Rehabilitation has convened on several occasions during the year to determine the progress being made on a directory of rehabilitation facilities in the State of New Jersey.

The committee's recommendation to the 1961 House of Delegates—that the House authorize the appropriation of $10,000 to the Special Committee on Rehabilitation for use in defraying the cost of full time personnel re-

quired to compile a directory of rehabilitation facilities in the State of New Jersey—was disapproved by the House in accordance with the comment and reasons given by the Board of Trustees, which voted disapproval for the reason "that it would be duplication of service since the information is available through the counties and through some State agencies."

Subsequently, the chairman of the special committee was appointed as the Society's liaison representative on the Directory Planning Committee of the New Jersey Conference on the Handicapped. He attended several meetings of the committee, and at a meeting on June 15, 1961, a prospectus for a directory of services for the handicapped and chronic ill was outlined. The function and scope of this directory was stated to be:

> The directory will furnish to professional individuals and to official and voluntary organizations a complete listing of all services available in the State and in adjacent areas for the handicapped and the chronic ill of all ages. The directory will be noteworthy by the fact that it will be kept current at all times through the use of a loose leaf system. Revision sheets will be mailed to subscribers at intervals.
>
> Financing: Funds for the initial printing of the directory have been assured by the DuPont Institute of the Nemours Foundation. Except for underwriting organizations there will be a service charge to each subscriber. This charge will include the initial directory, its supplements, and the news letter.

In order to stimulate the interest of other sources to contribute to this project, the special committee recommended—and the recommendation was endorsed by the Council on Public Health—that the Medical Society should demonstrate its interest in the project by pledging financial support; and based on a membership of close to 7,000 physicians, that The Medical Society of New Jersey pledge $7,000—one dollar per member toward the project. The Board of Trustees rejected this proposal.

It is the unanimous opinion of the Special Committee on Rehabilitation that a directory of rehabilitation facilities in the State of New Jersey is most desirable. This is evidenced by information required by other committees and physicians concerned in this phase of the practice of medicine. Compilation of a statewide directory cannot be successfully completed if the work is assigned to the individual county rehabilitation committees. Trained personnel must be employed to obtain full and specific information for each county. The county committees on rehabilitation can be most helpful to such personnel.

The committee reiterates its opinion that, in order to stimulate the interest of other sources to contribute to this project, The Medical Society of New Jersey should demonstrate its interest by pledging its financial support with the actual allocation of funds depending upon the financial support of other sources which have already indicated their interest.

RECOMMENDATION

That The Medical Society of New Jersey allocate $7,000 toward the initiation of the compilation of a directory of rehabilitation facilities in New Jersey—representing an approximate contribution of one dollar per member—toward the furnishing of a copy of the completed directory to each member.

Disapproved (page 449)

Approved, except for recommendation (page 449). Recommendation of reference committee adopted: That the activities of the Special Committee on the Chronically Ill and the Aging and on Rehabilitation be coordinated to avoid duplication of effort and cost toward establishing and maintaining a directory of rehabilitative services; and that the aid of the State Department of Health be enlisted to initiate and undertake this statewide project.

PROPOSED AMENDMENT TO THE CONSTITUTION

(Reference Committee on Constitution and Bylaws)

The following proposed amendment to the Constitution was accepted by the House of Delegates at the 1961 Annual Meeting, recognizing that such amendment must be considered by the House of Delegates for final vote in 1962. In compliance with the Constitutional provision regarding amendments, the proposal was sent to each component society and published in THE JOURNAL in January 1962.

ARTICLE IV — ORGANIZATION OF THE SOCIETY

Current	Proposed
SECTION 4 — DELEGATES	SECTION 4 — DELEGATES
(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.	(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each twenty (20) members or major fraction thereof, unless otherwise stipulated by the House of Delegates in the interest of maintaining the total membership of the House so that it does not exceed four hundred (400) members, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Adopted (page 438)

PROPOSED AMENDMENTS TO THE BYLAWS

(Reference Committee on Constitution and Bylaws)

The following proposed amendments to the Bylaws, as submitted in writing to the Secretary, were transmitted to the Committee on Revision of Constitution and Bylaws and to each component Society in February 1962— in accordance with the provisions of Chapter XII of the Bylaws.

1. From the Board of Trustees on recommendation of the Council on Public Relations:

Amend the appropriate section of the Society's Bylaws to include the following proviso:

> If a member of a council or committee—either appointed by the President or elected by the House of Delegates—absents himself from two consecutive meetings without excuse, he shall be presumed to have vacated his position on the council or committee, and the President shall fill the vacancy pro tem.

Recommended wording by Revisions Committee (page 384) adopted (page 438)

2. From the Board of Trustees on recommendation of the Committee on Medical Education:

Add the following paragraphs to Section 14 —Committee on Medical Education—of Chapter IX—Administrative Councils and Committees:

> (c) This committee should maintain an active interest in and make recommendations to The Medical Society of New Jersey with regard to the continuing medical education of its members.
>
> (d) This committee shall also maintain a continuing interest in the intern and resident training program in the State.

Recommended wording by Revisions Committee (page 384) adopted (page 438)

Resolutions • • •

1

APPLICATIONS FOR MEMBERSHIP

From the Hudson County Medical Society

(Reference Committee "A")

Whereas, component county medical societies of The Medical Society of New Jersey are subject to and must abide by the rules and regulations of the said Medical Society of New Jersey; and

Whereas, The Medical Society of New Jersey has incorporated into its Constitution and Bylaws the provision that each application for membership in a component medical society must be submitted to the said Medical Society of New Jersey which, through its Committee on Credentials, will examine the application for the purpose of determining the fitness of the applicant for membership as to education, degree acquired, and character and made the original ruling as to whether the county society may proceed with the processing of the application; and

Whereas, the above provision applies regardless of where or how the application originates; and

Whereas, The Medical Society of New Jersey may, pursuant to its right, reject a candidate; therefore be it

Resolved, that The Medical Society of New Jersey assume all the responsibilities resulting therefrom, and also assume the mechanics of notifying the candidate or applicant of its decision as to his election or rejection.

Not approved in present form (page 439)
Referred, with Board item on subject (page 354), to Special Committee on Revision of Constitution and Bylaws, for timely changes in the method by which members are accepted or rejected into the component society and the parent MSNJ.

2

CREDENTIAL FORMS

From the Hudson County Medical Society

(Reference Committee "A")

Whereas, the recently changed method of applying for membership in The Medical Society of New Jersey provides for two forms: one to be filled out at the time of the original application, and the second identical form to be filled out again upon request for promotion from associate to full membership; and

Whereas, this second application furnishes no additional information and merely serves to make extra clerical work on the part of the applicant, county medical society, State Society, and AMA; and

Whereas, in our opinion all of this could be replaced by a simple interval small form supplying information as to any change in status during the probationary period; therefore be it

Resolved, that the second application be replaced by a simple small form requesting only additional information regarding the time between applications.

Rejected (page 439)

Board item on subject adopted (page 355)

3

AMEF

From the Bergen County Medical Society

(Reference Committee "B")

Whereas, substantial sums are contributed annually through our State Society to the American Medical Education Foundation which, in turn, assigns such gifts to many medical schools that

a) have educated few, if any, New Jersey physicians,
b) have few, if any New Jersey students, and
c) in many cases have scant or no facilities for accepting New Jersey students; and

Whereas, such distribution of funds is prejudicial to institutions that have prior claim to the sentimental and monetary allegiance of New Jersey physicians; therefore be it

Resolved, that our Society obtain each year from its individual members an expression of each doctor's desire as to the allocation of his assessed contribution, and such monies as are transmitted to the AMEF be designated accordingly; and be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey for presentation to the House of Delegates at its 1962 Annual Meeting.

Adopted (page 440)

4

FINANCIAL REPORTS

From George Heller, M.D., Delegate from Bergen County

(Reference Committee "B")

Whereas, (a) the membership of The Medical Society of New Jersey has, in recent years, been asked to approve financial reports encompassing less than a full year; (b) no official statement of audit has been published in connection with these reports; (c) the reports submitted have violated the canons of accounting in that there has been a mingling of current expenses and capital investment, of receipts from dues with receipts from investments, of disposal of funds for our own purposes and those for ancillary organizations; and

Whereas, such handling of our funds has, in the past, been conducive to the failure to gainfully employ our reserve funds; and has resulted in obtaining a smaller return from invested capital than has, with due prudence and safety, been available; and

Whereas, neglect of the principle of "full disclosure" is conducive to laxity of supervision and intelligent use of funds and furnishes inadequate prevention from mishandling of funds in the future; therefore be it

Resolved, that our governing body be asked to implement promptly the following resolutions, these to be considered separately but consecutively at the 1962 meeting of our delegates:

Be it resolved that:

1) The delegates henceforth be presented with full yearly reports for their consideration.

2) A signed statement of audit defining the scope of such audit be appended to each report.

3) Methods of presentation of budget and yearly report be changed to facilitate full understanding, with comprehensive breakdown of such major items as "Public Relations," "Delegates' Expenses," and "Woman's Auxiliary."

4) Our Treasurer and Trustees be asked to use our capital funds in such a way as to obtain the largest return possible, consistent with the principles of prudence and safety.

Amended to read:

Be it resolved that:

1) The House of Delegates continue to be presented with full yearly financial reports for its consideration.

2) A signed statement defining the scope of the audit and a certification of the Treasurer's report be appended to each annual financial report.

3) Methods of presentation of yearly reports be changed to facilitate full understanding.

4) Our Treasurer and Trustees continue to use our capital funds in such a way as to obtain the largest return possible, consistent with the principles of prudence and safety.

Adopted as amended (page 440)

5

* MEDICAL CARE UNDER SOCIAL SECURITY

From the Union County Medical Society

(Reference Committee "E")

Whereas, the most favorable medical care of all people, including those over and under 65, is dependent on mutual respect and responsibility between patient and physician; and

Whereas, care for the aged, as for all, has been and should be best handled through local as against central government efforts and financial support; and

Whereas, Social Security as a setting for medical care coverage is felt to be undesirable for reasons, among others, of

1) its actuarial unsoundness and inequitability;
2) its failure to help those most in need;
3) its substitution of a welfare service for money, setting a dangerous and costly precedent;
4) its encouragement of malingering;
5) its compulsory nature;
6) its furnishing of benefits to those who have not contributed and also to many not needing or desiring such benefits; and
7) its inferiority to the Kerr-Mills Bill in handling proved needs; and

Whereas, the House of Delegates of the American Medical Association (in the Terrell resolution) advised the several state medical associations and the many county medical societies to recognize the impending threat, "and to prepare now for any eventuality by continuing to oppose any scheme which tries to impose a substandard system of medical care on the American people"; and

Whereas, further, the American Medical Association has expressed in the Bauer resolution "it (AMA) will not be a willing party to implementing any system which we believe to be detrimental to the public welfare"; and

Whereas, it is our strong conviction that the social security support of any type of medical services *does* try to impose a substandard system of medical care on the American people so served, and thus *will* be detrimental to the public welfare; therefore be it

Resolved, that the Union County Medical Society go officially on record as supporting the principle of the American Medical Association (Bauer and Terrell) resolutions; and be it further

Resolved, that the Union County Medical Society interprets these resolutions as indicating, and hereby does itself express, an unwillingness voluntarily to practice medicine under any system of medical care financed through the Social Security mechanism.

Not approved (page 447)—together with Resolutions #6 and #16—in view of the action of the House in conjunction with the supplemental report of the Board on HR 4222 (page 361).

***Clarification of reference committee adopted: That the term "medical care" or "medicare" is a misnomer for what is actually a proposed "hospital-nursing care" tax program under Social Security.**

6

*MEDICAL CARE UNDER SOCIAL SECURITY

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, the House of Delegates of the American Medical Association in June 1961 endorsed the statement of principle of its senior statesman, Dr. Louis H. Bauer, which reads as follows:

The House of Delegates of the American Medical Association records its opposition to any legislation of the King-Anderson type. Its opposition is based on the facts that such legislation does not meet the needs of the situation; interferes with the doctor-patient relationship; interferes with the rights of doctors employed in hospitals; is inordinately expensive; leads inevitably to further encroachment by government into medical care; results eventually in a deterioration of the type of medical care rendered the public; and is therefore detrimental to the public interest.

The House of Delegates invites attention to the fact that the medical profession is the only group which can render medical care under any system and that the medical profession is best qualified to determine how the best medical care can be delivered.

The House of Delegates believes that the medical profession will see to it that every person receives the best available medical care regardless of his ability to pay; and it further believes that the profession will render that care according to the system it believes is in the public interest; and that it will not be a willing party to implementing any system which it believes to be detrimental to the public welfare; and

Whereas, the Federal Administration continues to push for a type of medical care for the elderly regarded by most physicians as inimical to the best interests of both patient and physician; and

Whereas, the Administration has done little or nothing to promote the implementation of the Kerr-Mills law and has in fact belittled its value; now therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey recognize the impending threat and start immediate preparation to implement the Bauer statement.

Not approved (page 447)—together with Resolutions #5 and #16—in view of the action of the House in conjunction with the supplemental report of the Board on HR 4222 (page 361).

***Clarification of reference committees adopted: That the term "medical care" or "medicare" is a misnomer for what is actually a proposed "hospital-nursing care" tax program under Social Security.**

7

VENDOR PAYMENTS IN WELFARE CASES

From the Burlington County Medical Society

(Reference Committee "F")

Whereas, the physicians, pharmacists, and other professional groups of Burlington County have long been desirous of a Vendor Payment Plan, rather than Client Payment Plan, in the cases of the Old Age Assistance Program, the Assistance for the Permanently and Totally Disabled Program, and the Assistance for Dependent Children; and

Whereas, the physicians, pharmacists, and special health agencies of Burlington County are now in receipt of such a plan with the attached invoice form M.D., invoice form R.X., and invoice form M-3, all in triplicate; and

Whereas, many of the Welfare Boards, as well as the County Welfare Committees, have been ignored so far as recommendations, particu-

larly to the voluminous forms, were concerned, in particular that a separate voucher be submitted for each visit and each prescription; and

Whereas, such forms will considerably increase the budget of the Welfare Boards, not only in the purchase of the form but also in adjusting their personnel to handle the load; and

Whereas, the difficulties of having the clients sign the invoice forms per visit (as against the previous routine of signing one form for the several visits during any one given month) will quadruple the efforts of physicians; and

Whereas, the proposed requirement that prior approval of the Welfare Board be obtained before services are given, except in certain emergency situations, would invoke additional effort on the part of physicians; now therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey recommend to the Department of Institutions and Agencies of the State of New Jersey that the invoice forms be reconsidered and simplified for the use of all those concerned; and be it further

Resolved, that the proposed requirement that prior approval of the Welfare Board be obtained before services are given except in certain emergency situations be dispensed with.

Approved (page 448)

Recommendation of reference committee adopted: That the subcommittee of the Council on Medical Services continue its activity to effectuate the intent of the resolution.

8

SENATE BILL 142*

From Robert Brill, M.D., Delegate from Passaic County

(Reference Committee "E")

Whereas, the Medical-Surgical Plan of New Jersey was established by physicians to ensure the best medical care available for the people of the community, through direct responsibility of the Plan to physicians only; and

Whereas, an effort is being made by the sponsors of Senate Bill 142 to alter the original intent of the Medical-Surgical Plan of New Jersey by permitting the payment of fees to other than licensed physicians, for laboratory medical services; and

Whereas, passage of such a bill would encourage and allow other para-medical groups to participate in the Plan; and

Whereas, in this important matter, The Medical Society of New Jersey has taken a position of "no action"; therefore be it

Resolved, that The Medical Society of New Jersey change its position to one of "immediate active opposition."

(*S-142 Stout—To provide that services performed by a duly registered bioanalytical laboratory are within the scope of medical service plans.)

Disapproved (page 445)

Action of Board approved (page 360)

9

DISTINCTION BETWEEN BLUE CROSS AND BLUE SHIELD

From the Mercer County Medical Society

(Reference Committee "C")

Whereas, Blue Cross recently placed a request for an increase in premium rates with the New Jersey Banking and Insurance Commissioner; and

Whereas, considerable confusion exists in the minds of the public as to the part physicians' fees play in the rising costs of Blue Cross; and

Whereas, Blue Cross should issue clearly understood statements denying this premise since physicians' fees actually play no direct part in hospital costs; and

Whereas, Blue Cross should also emphasize that the main reason for increasing rates is due to the increasing costs of labor which form 70 per cent to 85 per cent of hospital running expenses; and

Whereas, many hospitals throughout the State of New Jersey have for several years assisted the Blue Cross by the actions of Tissue and Bed Utilization Committees who investigate admissions and work constantly to avoid unnecessary and prolonged hospital stays; and

Whereas, statements received by subscribers for premiums due add to this confusion since the premium rates of Blue Cross and Blue Shield are not separately identified but instead are lumped together into one sum; therefore be it

Resolved, that The Medical Society of New Jersey should alert the public at frequent intervals of the fact that the Blue Cross costs are not related to doctors' fees, nor do these fees play a part in any direct way with rising labor and other costs of hospitals; and be it further

Resolved, that The Medical Society of New Jersey apprise the public of the efforts being made by hospital staffs to prevent unnecessary hospitalization; and be it further

Resolved, that the Board of Trustees of the Medical-Surgical Plan identify its premium rates as separate and distinct from those of Blue Cross; and be it further

Resolved, that a copy of these resolutions be forwarded to the Board of Trustees of the Medical-Surgical Plan, the Boards of Trustees of the Hospital Service Plan, the President and Board of Trustees of The Medical Society of New Jersey; and be it further

Resolved, that these resolutions be presented for appropriate action at the next meeting of the House of Delegates of The Medical Society of New Jersey.

Approved (page 442)

10

AMA LISTS OF PHYSICIANS

From the Mercer County Medical Society

(Reference Committee "A")

Whereas, the American Medical Association has stated in correspondence with the Mercer County Component Medical Society that it distributes lists of physicians' names and addresses to non-medical facilities and receives fees for this service; and

Whereas, such activity of the American Medical Association serves no useful purpose in either the field of medical science or education but facilitates justified criticism of the Association; and

Whereas, such lists have been utilized to bring physicians within the purview of commercial stock promoters; therefore be it

Resolved, that the Mercer County Component Medical Society officially condemns any such activities of the American Medical Association and any of its employees so engaged and demands that there be an immediate cessation of such activity and that this resolution be submitted to the House of Delegates of The Medical Society of New Jersey and the American Medical Association for further action.

Not adopted (page 440) because "Lists" mentioned need clarification.

Referred to the Board of Trustees and AMA delegates and alternate-delegates, for further investigation and clarification.

Supplemental Resolutions

11

INTERNS

From the Camden County Medical Society

(Reference Committee "D")

Whereas, there is a shortage of graduates of medical schools to fill the available internships in approved programs in the numerous community hospitals within the United States; and

Whereas, the community hospital is the backbone of medicine as practiced in this country and offers the medical graduate the opportunity to develop a position in medicine at the community level where he will eventually practice; and

Whereas, there are recent trends by large medical centers to corral all graduates into their programs by offering straight internships and opportunities in residency programs if they accept their internship; therefore be it

Resolved, that The Medical Society of New Jersey direct its delegates to the American Medical Association to recommend that the Association be made aware of the dangers to the medical graduates and to the community hospitals of the present practices of the medical centers to bring pressure on the medical graduates to intern in the medical centers, and that the Association take the necessary steps to encourage the medical graduate to seek his internship in his own community hospital.

Amended to read:

Resolved, that The Medical Society of New Jersey direct its delegates to the American Medical Association to recommend that the association be made aware of the dangers to the medical graduates and to the community hospitals AND TO THE PUBLIC AT LARGE of the present practices of medical centers . . .

Approved as amended (page 445)

12

HSP IN-PATIENT TESTS

From the Camden County Medical Society

(Reference Committee "C")

Whereas, it has come to the attention of the Camden County Medical Society that in the past six weeks the New Jersey Blue Cross has disqualified for payment certain tests completed on hospital inpatients, stating that these tests were not in any way related to the patients' diagnosis; and

Whereas, this declaring of various tests ineligible under the New Jersey Blue Cross Plan is to force the patients to pay for these tests personally and directly to involved hospitals, thereby creating dissatisfaction among patients, with attendant criticism of not only the B'ue Cross but also of the physicians and the hospitals involved directly and indirectly; therefore be it

Resolved, that this Society feels it advisable that the New Jersey Blue Cross Plan contact the attending physician involved in all future cases regarding their opinion of the necessity of questionable tests completed on inpatients prior to any disqualifying procedure. The hospital staff concerned—and if need be, the county medical society—would be the definitive disciplinary agencies, should habitual physician offenders be exposed.

Approved (page 443)

Physicians urged to discuss the Blue Cross contract limitations with their patients BEFORE ordering examinations and services.

13

PUBLIC EDUCATIONAL PROGRAM

From the Hudson County Medical Society

(Reference Committee "E")

Whereas, for the past year and a half the physicians of this country and state have been maligned, ridiculed, made out to be ogres of the worst kind by politicians, union leaders, and other irresponsible individuals; and

Whereas, the physicians have followed the Biblical teachings and have turned all their cheeks until they have been slapped and kicked to such an extent that even meek Caspar Milquetoasts are beginning to rebel; and

Whereas, our patients are beginning to wonder whether all the things that are said about us are true, because no red-blooded individual would sit and take it without rebuttal unless all of these allegations are true; therefore be it

Resolved, that since the AMA, our parent organization, has been sitting on the sidelines watching its children slaughtered, The Medical Society of New Jersey should immediately start a day-by-day educational program, by means of paid newspaper advertisements by our publicity department, giving the physicians' side of the story, such as: (1) what we stand for; (2) why the politicians are fighting for the people; (3) why we are for the Kerr-Mills Bill and against the King-Anderson Bill, and give the differences between the two bills; (4) name all the organizations who are behind us—such as the Chamber of Commerce, the insurance companies, the Farmers' Association, etc.

Not adopted (page 447)

Referred to the Board of Trustees and the Council on Public Relations for study and implementation. (Reference committee agreed with spirit and intent of resolution.)

14

KERR-MILLS ACT

From the Mercer County Medical Society

(Reference Committee "E")

Whereas, the Congress of the United States in 1960 enacted legislation known as the Kerr-Mills Act, designed to provide financial assistance for aged ill; and

Whereas, the Kerr-Mills Act requires implementing legislation by the states before its benefits can be made available to the residents of each state; and

Whereas, there are aged ill in New Jersey who are suffering from the lack of such available financial assistance; and

Whereas, a great many states of the United States have adopted the required legislation to financially aid their aged ill; therefore be it

Resolved, that the Mercer County Component Medical Society urge the Legislature of New Jersey to take immediate steps to make the benefits of the Kerr-Mills Act available to the needy senior citizens of New Jersey and to end their inaction on this most serious matter; and be it further

Resolved, that the Mercer County Component Medical Society urge the House of Delegates of The Medical Society of New Jersey to concur in the purpose and spirit of this resolution.

Adopted (page 447)

Referred to Board of Trustees for possible implementation.

15

PUBLIC STATEMENTS

From S. William Kalb, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, the medical profession in general has received poor expression through the public media; and

Whereas, recently in New Jersey, doctors have been getting particularly poor newspaper, radio, and TV publicity; and

Whereas, timely, emphatic statements to the public media could do much to offset adverse opinion if presented while they still have immediate news value; therefore be it

Resolved, that The Medical Society of New Jersey, through some modality, present a definite and emphatic position on any newsworthy matter concerning physicians which is of current public interest within twenty-four hours after the matter has become public domain; and be it further

Resolved, that one spokesman be appointed to read this official Medical Society position to any and all interested representatives of public media.

Disapproved (page 447), because the Society's record of achievement in this area does not support the implications of this resolution.

16

*MEDICAL CARE UNDER SOCIAL SECURITY

From Robert H. Areson, M.D., Delegate from Essex County

(Reference Committee "E")

Whereas, the medical profession has always provided the highest quality of medical care to all economic groups; has never discriminated in providing medical care against any person regard'ess of race, creed or co'or; and is dedicated to the prevention, early diagnosis, and treatment of all diseases and to the rehabilitation of all persons; and

Whereas, the medical profession believes that the individual should provide for increased costs of medical care for himself and his dependents whenever possible through private income or private voluntary prepayment health, hospital or other similar insurance plans; and that the increased costs of medical care have been largely due to the cost of materials, supplies, and wages and not to physicians' fees; and

Whereas, the medical profession believes in the democratic principle of helping those who cannot help themselves and recognizes the need of some members of our population for medical assistance for the aged who can provide for their daily necessities but who need financial assistance for unusual medical or hospital expenses; and

Whereas, the medical profession is fully aware that health cannot be legislated by an "Act of Congress" or an administrative edict, but is maintained through the conscientious application of medical principles by dedicated physicians; and that American physicians have attained the highest quality of medical care throughout the world under the system of free enterprise; and

Whereas, the medical profession is composed of physicians who are also citizens in a free democracy with the same Constitutional rights to free speech as all other citizens and with the same Constitutional rights to express their opinions either for or against any pending legislation as all other citizens; and

Whereas, the King-Anderson Bill as now written is restricted to part payment through Social Security, with limited coverage and initial deductibles for hospitals and nursing facilities approved by and contracting with the Federal Government, for a limited number of persons who are eligible under Social Security; and

Whereas, the King-Anderson Bill or similar bills could be extended under the Social Security Act to control physicians' fees, the type and frequency of services, medications, appliances, and allied professional services with constant governmental intervention, supervision, restriction and regulation;

Therefore be it **Resolved**:

1) That the members of The Medical Society of New Jersey reaffirm their intentions to continue to provide the highest quality of medical care to all persons regardless of their economic status, race, creed, or color;

2) That we continue strongly to support the democratic principle of free enterprise in the private practice of medicine to include the confidential patient-physician relationship, the right of free-choice-of-physician, and the fee-for-service principle;

3) That we, as citizens in a free democracy, emphatically oppose any attempt to intimidate the medical profession by threats or punitive legislation which will deny or interfere with the right of any physician to choose his type of practice or patients;

4) That we strongly oppose the King-Anderson Bill, which makes no provision for over two million persons over 65 years of age who are not covered by Social Security; a compulsory Social Security health tax; and any future extension of the Social Security or similar acts with governmental intervention, supervision, restriction, regulation, and control of the private voluntary prepayment health, hospital, or other similar insurance plans, or the private practice of medicine;

5) That we endorse the democratic principle of prepayment for medical care through the private voluntary prepayment health, hospital, and similar insurance plans or from private resources;

6) That we endorse the expansion of these private voluntary plans to provide insurance coverage for all persons over 65 years of age and their dependents, and for those who become totally disabled;

***Clarification of reference committee adopted: That the term "medical care" or "medicare" is a misnomer for what is actually a proposed "hospital-nursing care" tax program under Social Security.**

7) That we strongly endorse the Kerr-Mills Law which, when properly implemented and administered, will provide adequate financial assistance through federal funds to the states on a matching basis for all persons over 65 years of age who cannot meet their medical and hospital costs through private voluntary prepayment insurance plans or from their own resources; and

8) That this resolution be presented to the House of Delegates of The Medical Society of New Jersey at its annual convention for approval; and if approved, that a copy of this resolution be sent to the President of the United States, the Governor of New Jersey, the New Jersey Senators and Representatives in the Congress, New Jersey State Senators and Assemblymen, and the American Medical Association.

Not approved (page 447)—together with Resolutions #5 and #6—in view of the action of the House in conjunction with the supplemental report of the Board on HR 4222 (page 361).

17

DAVID BACHARACH ALLMAN, M.D.

From the Medical Society of Atlantic County

Whereas, this year—in consequence of the stipulation of the Bylaws of The Medical Society of New Jersey—David B. Allman, M.D., of Atlantic City, is ineligible for re-election to the Society's Board of Trustees; and

Whereas, since 1947 Doctor Allman has rendered distinguished service to The Medical Society of New Jersey as a Board member from the Fifth Judicial District; and

Whereas, through his entire career, as a physician and surgeon Doctor Allman has given unstintingly of himself in the service of Medicine and of the people; and

Whereas, as President of the American Medical Association in 1957-58, Doctor Allman reflected great and unprecedented credit upon the Medical Society of Atlantic County and The Medical Society of New Jersey; now therefore be it

Resolved, that the Atlantic County Medical Society hail Doctor Allman as an illustrious son in whom it is well pleased; and be it further

Resolved, that the Medical Society of Atlantic County invite the House of Delegates of The Medical Society of New Jersey to join in this heartfelt tribute to Doctor Allman as an exemplary representative of the medical profession and as a great and good man.

Adopted by acclamation at the first session.

18

INTRAVENOUS THERAPY BY NURSES

From Joseph M. Gannon, M.D., Delegate from Union County

(Reference Committee "F")

Whereas, the dwindling of the house staffs of New Jersey hospitals has necessitated increased utilization of the services of professional nurses, especially for the purpose of intravenous therapy; and

Whereas, the New Jersey Board of Nursing which exercises control over professional nurses, including their giving of intravenous therapy, has been unduly restrictive in this connection; and

Whereas, this situation militates against the welfare of the patient; therefore be it

Resolved, that The Medical Society of New Jersey, through an appropriate committee, address itself to the New Jersey Board of Nursing for the purpose of inducing that agency to amend its regulations regarding intravenous therapy so as to make them more consonant with good medical practice and adequate patient care.

Accepted (page 448)

19

KERR-MILLS ACT

From the Gloucester County Medical Society

(Reference Committee "E")

Whereas, the Kerr-Mills Law, providing federal funds to be used for health care for persons of limited means who are over the age of sixty-five, has been in effect since 1960, and

Whereas, New Jersey is the third richest state in the nation; and

Whereas, there are people over sixty-five in New Jersey who are not indigent and yet need financial aid to help meet health care needs; and

Whereas, the New Jersey legislators acknowledge this need and yet have not acted to pass legislation to fulfill this need; and

Whereas, the legislators of New Jersey, by not acting on implementation of the Kerr-Mills Law, have deprived our over sixty-five citizens of these funds for the past two years; therefore be it

Resolved, that this body of delegates of The Medical Society of New Jersey do agree that there is need for immediate implementation of the Kerr-Mills Law here in New Jersey; and be it further

Resolved, that a copy of this resolution be sent to all legislators and to the Governor of our state.

Adopted (page 447)

Referred to the Board of Trustees for any possible implementation.

20

RECENT RESOLUTION OF NEW JERSEY ASSEMBLY

From David Eckstein, M.D., Delegate from Mercer County

(Reference Committee "E")

Whereas, and although, proposed punitive legislation recently brought before the State Assembly of New Jersey has been well and clear'y answered by Doctor Buchanan in the press throughout the State, and the report delivered by Doctor Mulligan on this date further clarifies our stand, no specific note has been made of a recently passed resolution in the Assembly of the State of New Jersey by a voice vote in the manner of a lynch mob; and

Whereas, the Assembly of the State of New Jersey has permitted itself to go on record in the form of a resolution which constitutes a malicious, puerile, and unfounded attack on the entire medical profession of New Jersey; and, although all details of this said resolution have not been spelled out, detailed direct quotes are a matter of record in the public press; therefore be it

Resolved, that the President of The Medical Society of New Jersey and the Board of Trustees be empowered, and urged, to take any vigorous action necessary to point out to the Assembly and the citizens of New Jersey the slanderous, vindictive, and wholly unfair nature of this resolution; and be it further

Resolved, that the Assembly of the State of New Jersey be apprised of our feelings in this matter by the most direct means possible.

Second paragraph amended by sponsor, as follows: Whereas, IT IS REPORTED THAT the Assembly of the State of New Jersey . . .

Adopted as amended (page 447)

21

AMA DELEGATES

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, recognizing that, in the election of delegates from The Medical Society of New Jersey to the American Medical Association, the opinions of the candidates selected by the Nominating Committee on important medical, economic, and social problems are unknown to most delegates to the State Society at the time of voting; and

Believing that, without such knowledge, the delegates to the State Society can neither support these candidates intelligently nor reasonably offer additional nominations from the floor; and judging from this manner of selection that the elected delegates to the American Medical Association may not be representative of the majority opinion of the delegates to the State Society; therefore be it

Resolved, that the Nominating Committee request their nominees for the offices of delegate and alternate to prepare a brief (3 minute) statement of their views on those questions which they believe will merit serious consideration at the next meeting of the House of Delegates of the American Medical Association, this statement to be presented to the House of Delegates of the State Society prior to the election; and be it further

Resolved, that the House of Delegates of the State Society then elect by regular procedure the delegates and alternates to the American Medical Association.

Rejected (page 440), because such action would be discriminatory against these delegates and their alternates, inasmuch as no other nominated officer of the Society is required to make similar statements.

22

HOME AND/OR NURSING HOME CARE UNDER BLUE SHIELD

From Irving M. Levitas, M.D., Delegate from Bergen County

(Reference Committee "C")

Whereas, Blue Cross of New Jersey at present has four experimental pilot programs with hospitals in this state to study the feasibility of including home and/or nursing home benefits and Blue Shield has no such program to provide coverage for its subscribers who have both Blue Cross and Blue Shield policies; therefore be it

Resolved, that the New Jersey Blue Shield Association immediately cooperate with New Jersey Blue Cross to offer coverage for those patients who come under this Blue Cross pilot program.

Approved (page 443)

Recommendation of reference committee adopted: That Blue Shield's study of a program to implement a pilot study be continued.

23

BASIC MINIMUM HOSPITAL AND NURSING HOME CARE

*From James H. Brothers, III, M.D., Delegate from Essex County

(Reference Committee "C")

Whereas, the cost of hospitalization has risen over 700 per cent in the past 20 years (going from $65 in 1940 for a 10-day stay in a two-bed room, including medication, to over $425 in 1960);

Whereas, the present New Jersey Blue Cross insurance policy provides hospital care for 120 days for those under 70 and only 21 days of hospital care for those over 70;

Whereas, there are many hospital insurance plans written paying from between $5 and $15 per hospital day, allowing grossly inadequate coverage which is completely unrealistic;

Whereas, the cost to the subscriber in hospital plans is constantly increasing for basic hospital care in each of the fifty states (in New Jersey it increased 19.95 per cent for this year, and in New York Blue Cross went into deficit $5 million.);

Whereas, it is felt that there is no adequate provision in any existing health policy for the care of the chronically ill;

Whereas, the King-Anderson as well as other health bills concern themselves only with those over 65, we have all seen families financially crushed as a result of the cost of hospitalization or the care of the chronically ill of much younger persons;

Whereas, there is estimated to be in excess of 1 billion dollars in monies not available to the Department of Internal Revenue because of the failure of individuals to file income tax returns and the impossibility under existing circumstances of tracing them; and

Whereas, it is our belief that hospitals should maintain their private integrity, controlled by the citizens in their own community area, and that each of the 50 states—and not the federal government—should be responsible for the hospital care of their citizens; now therefore be it

Resolved, that

1) An actuarial group be appointed in each state by the individual state to determine the exact cost of hospitalization for all citizens of that state in a hospital for 365 days each year, in a four or more bed room, including the necessary medication and ancillary facility excepting medical fees, and for the chronically ill to be placed in certified nursing homes (according to individual state laws) for 365 days each year in a six or more bed room, including medications—these chronically ill to be so certified by at least three practicing doctors; hospitalization at the time of certification not being required;

2) A group in each of the fifty states be named by that state for the purpose of administering the plan in the state—this group to be organized in a similar manner as the present board of trustees of the New Jersey Blue Cross; the cost of the plan, after the first year, to be based on the experience of the preceding year. Over the years a good evaluation of the efficiency of the plan in each state may be determined by comparing the cost of the plan in each of the fifty states.

3) All citizens 19 years and over be required to file an income tax return each year with the federal government, regardless of income;

4) On each income tax return be a provision on the amounts owed based on the cost figured for each state, and the schedule on each return be that of the state in which the individual resides. All with an income of $4,500, or more, would pay 100 per cent of the cost of the plan in his state, married couples without maternity benefits and single individuals would have a percentage differential. The cost would then be down-graded by $500 increments, exact percentages to be determined later. The federal government would then add the funds necessary to bring all of the returns to 100 per cent of that amount required in the individual state. Monies would then be returned to each of the fifty states to be administered by the aforementioned group, the federal government to be a collection agency only;

5) Any agency, private or otherwise, with funds in reserve on a prepayment or annuity plan involving hospitalization or care of the chronically ill, reorganize these funds for their subscribers, if they so desire, to supplement this basic minimum hospital and nursing home plan. To supplement this plan, private insurance companies would be urged to write medical-surgical and extended hospital insurance.

Referred to Board of Trustees (page 443) for study and action, for report at the next annual meeting.

*Opening Remarks to Resolution

Gentlemen: I have a resolution to present to the House in answer to the various health bills being considered at federal and state levels. I have discussed my proposals with over 200 doctors and numerous laymen in allied fields. The general feeling seems to be that NOW is the time for presentation, although we are all aware that the figures used will need actuarial revisions. I believe this resolution to be sound from an economical and a humanitarian point of view.

First, I would like to state that I oppose the King-Anderson Bill on the grounds that it does not include all people over the age of 65, but only 80 per cent of the 17 million that are in this category. This makes it ineffective. Secondly, it may lead in the future to the specialization of medicine. Thirdly, what is necessary is the hospitalization and nursing home plan that will provide the basic and minimum for the care of those over 65 years of age not for any time limit, but until such need has ceased. Fourthly, anyone who has had any experience in the hospitals fully realizes how difficult it is to move one from a hospital bed to a nursing home as King-Anderson requires. It would be better to have disposition made without this intermediate step. Surely we are all concerned with the problems of the aged, especially when it is stated by Secretary Ribicoff that 76 per cent of all males and 91 per cent of all the females not institutionalized, over the age of 65, have a yearly income of less than $2,000. It is, therefore, impossible for people in this age bracket to carry expensive insurance and also meet their daily needs. Many attempts have been made and are being made to write insurance policies that would cover the hospitalization of this group; but none have dealt adequately with the needs of the chronically ill, nor have they been able to price these policies within realistic reach for their economic status.

We are concerned also with the very unfavorable and unfair publicity concerning doctors in recent years. It appears that this is caused primarily by two serious misunderstandings of the doctors' position in the minds of the lay public: First, it is the hospital costs which have skyrocketed over 700 per cent in the past 20 years due to the increase in the cost of living and the dollar devaluation. Doctors' fees have not risen in any like manner; and second, in our press releases, we as a group have seemed to take a negative approach to any change. I think the time has come for us to be positive. My proposition is a compulsory insurance program for minimum basic hospital care and nursing home care for the entire population with premium costs apportioned accordingly; supplemented by our government (for those with an income below $4,500), from monies made available by collection of income tax revenues, which to date have for one reason or another been uncollectable. The premium costs would vary from state to state.

1961 TRANSACTIONS

At its first session on Saturday afternoon, May 12, 1962, the House of Delegates **approved:**

The Transactions of the 1961 House of Delegates as published in the July 1961 JOURNAL and distributed to the membership.

MEDICAL SERVICE ADMINISTRATION OF NEW JERSEY

Royal A. Schaaf, M.D., President, Board of Governors

(Reference Committee "C")

During 1961 Medical Service Administration of New Jersey has been active in the operation of the City of Newark Medical Plan and the Medicare Program of the United States Government

NEWARK MEDICAL PLAN

The Newark Medical Plan provides for medical services rendered in the homes of indigent and medically indigent persons by physicians of the patient's choice on a fee-for-service basis; in instances where a patient has no family physician, a telephone call to the Newark Division of Health at any hour of the day or night, will bring a physician to the home of the patient within a short time.

The Newark Plan, operated on a "cost plus," rather than on an insurance basis, represents a prime example of how the problem of public medical care to the indigent and medically indigent patient may be met through cooperation of an official health agency with a voluntary non-profit agency established by the medical profession.

The classification of *indigent* is applied to those persons whose names appear on the Welfare rolls of the City of Newark; the *medically indigent* are those who are considered by the City Division of Health as having sufficient income to meet the necessities of an adequate standard of living, but which income is insufficient to pay for needed medical care.

Forty-three physicians participated in the program during 1961.

The Essex County Medical Society has cooperated by supplying new physicians to the panel available to serve the needy of the City of Newark on a twenty-four hour basis, particularly for night and weekend calls.

Following are the statistics for *approved* services rendered from January 1 to December 31, 1961, as compared with former years:

	RELIEF				
Year	1957	1958	1959	1960	1961
Number of cases served	1556	1655	2154	1654	1484
Value of approved services	$7,000.50	$7,630.00	$10,791.00	$7,417.00	$6,914.00
	MEDICALLY INDIGENT				
Number of cases served	4291	3703	3425	2553	1732
Value of approved services	$17,662.50	$15,420.00	$16,439.00	$11,979.00	$8,197.00

Processing of physicians' statements involves a time lag of two months from the time services were rendered to time checks are mailed to the physicians who rendered the services; i.e., services rendered in November would be paid for in January.

In 1961, Medical Service Administration received from the City of Newark $17,756.20 for services rendered from November 1960 to and including October 1961; this amount was allocated as follows:

	For Physicians' Fees	Plus 10 Per Cent Service Charge (Income to MSA)	Representing Number of Visits
Division of Welfare (Relief)	$7,031.00	$ 703.10	1,530
Division of Health (Med. Ind.)	9,111.00	911.10	1,942
TOTAL	$16,142.00	$ 1,614.20	3,472

During 1961 the City of Newark apparently was free of the kinds of illnesses which require visits to the patient's home. There was less sickness among the relief and medically indigent cases that year, and therefore fewer calls for physicians' services in the home, which accounts in part for the large drop in services rendered to the City during 1961. In addition, a substantial number of persons formerly on the Relief Rolls of the City were absorbed by the Essex County Welfare Board.

MEDICARE PROGRAM

Medical Service Administration of New Jersey completed its fifth year as Fiscal Agent for The Medical Society of New Jersey in the administration of the physicians' part of the Medical Care Program for dependents of members of the armed services, which was implemented by the Department of the Army on December 7, 1956. Under this program, popularly known as "Medicare," wives (or dependent husbands) and children of persons in active military service, qualify for medical, surgical, obstetrical and hospital services rendered by civilian physicians and hospitals at the expense of the Federal Government.

The physicians' aspect of Medicare continued to function smoothly during 1961, due in large measure to the experience gained in the previous years of operating the Medical Care Program for servicemen.

A review of the accomplishments of the Medicare Program in New Jersey since its inception in December 1956 is presented herewith:

CLAIM EXPERIENCE

Period	Received	Declined	Returned as Incomplete	Paid Claims	Paid Amount	On Hand
Dec. 7, 1956 - Dec. 31, 1957	10,017	320	3,179	5,982	$ 489,265	356
Jan. 1, 1958 - Dec. 31, 1958	14,014	377	3,758	9,298	778,551	1082
*Jan. 1, 1959 - Dec. 31, 1959	7,384	385	1,972	5,908	494,691	206
**Jan. 1, 1960 - Dec. 31, 1960	7,925	197	2,384	4,930	413,687	610
Jan. 1, 1961 - Dec. 31, 1961	7,241	244	1,921	5,681	466,848	5
TOTAL	46,581	1,523	13,214	31,799	$ 2,643,042	5

*Effective October 1, 1958, certain types of care were no longer authorized in civilian facilities.

**Effective January 1, 1960, certain of the benefits curtailed in October 1958 were restored for government coverage.

It is interesting to note that only 5 unpaid claims were on hand at December 31, 1961; this unusual feat was accomplished to avoid re-coding of claims, due to the new, revised claim form (DA 1863-2) which became effective January 1, 1962.

It will be noted that of the 7,241 physicians' claims received in 1961, 1,921, or more than 26 per cent have had to be returned as incomplete or incorrect. Although the actual number and proportion of claims returned has notably decreased in 1961 as compared to prior years, it is hoped that with the use of the new, revised claim form DA 1863-2, prepared for the exclusive use of physicians and dentists, the number of returned claims will decrease significantly.

Emphasis is placed on the point that of the claims presented to the Office for Dependents' Medical Care for payment in 1961, only three (3), in the amount of $155.00, were rejected for payment. These have been re-submitted, but have not as yet been reimbursed.

1,761 physicians participated in the Medicare Program during 1961.

REVISED CLAIM FORMS

The *Statement of Services Provided by Civilian Medical Sources,* (DA 1863 form) has been revised and became effective January 1, 1962.

The new claim form DA 1863-2 is *buff* colored and is designed specifically for the use of physicians and dentists. It is hoped that the use of a claim form exclusively for physicians and dentists will expedite the preparation and processing of the claim load and significantly reduce the number of claims returned because they were incomplete or incorrectly prepared. A supply of the new buff colored DA 1863-2 claim forms may be obtained by request to Medical Service Administration.

As an item of information, a separate form, DA 1863-1, blue-colored, has been provided to

report Medicare services provided by hospitals. Further details concerning the revised Medicare claim forms may be found in the February issue of The Journal of The Medical Society of New Jersey.

REVISION OF APPENDIX A OF MEDICARE CONTRACT

The new claim form DA 1863-2 was the result of a complete revision of Appendix A to the Medicare contract.

The former Appendix A has been deleted in its entirety, and the new, revised Appendix A, effective January 1, 1962, and consisting of fifty-five pages, was substituted in lieu thereof to reduce IBM machine accounting costs.

MEDICARE CONTRACT

The original Medicare contract No. DA-49-007-MD-831, having been extended each year with various modifications, expired on June 30, 1961.

Instead of extending the same contract, a new contract, No. DA-49-192-MD-32, was executed by The Medical Society of New Jersey and Medical Service Administration of New Jersey with the United States Government, Department of the Army, under date of July 1, 1961.

The new contract essentially consolidates all of the provisions of the old contract *except for the fee schedule*. The entire present fee schedule is incorporated in the present contract by reference.

Subsequently, Medical Service Administration of New Jersey renewed the subcontract with Hospital Service Plan of New Jersey for the performance at cost of the administrative services under the prime contract; which services are performed in the name of Medical Service Administration of New Jersey.

SCHEDULE OF ALLOWANCES (FEES)

The Schedule of Allowances for services performed under the Medicare Program was negotiated by the Special Medicare Committee of The Medical Society of New Jersey with the Department of the Army. There have been no changes in the current Schedule of Allowances which became effective in October 1958, and, in which, the agreed-upon-fees compare favorably with those provided by the Medical-Surgical Plan of New Jersey for similar procedures. For reasons stated elsewhere in this report, copies of the Schedule of Allowances are no longer available for distribution to the physicians of New Jersey.

PROVISION FOR ADJUSTMENT OF FEES

In connection with unusual procedures in which a physician believes he is entitled to a fee in excess of that provided under the Schedule of Allowances, he may submit a Special Report to Medical Service Administration. Such report is referred to the Special Medicare Committee of The Medical Society of New Jersey for review and recommendation. The Committee's recommendation is then forwarded to the Federal Government for consideration. Notification of the amount approved for payment by the Federal Government is subsequently returned to Medical Service Administration for remittance to the physician.

At this point, special commendation is accorded to the members of the Special Medicare Committee of The Medical Society of New Jersey, who, as in the past, have continued their careful and conscientious consideration of each case submitted to them for review. Practically without exception, the Office for Dependents' Medical Care in Washington, D. C. has concurred in the recommendations of the Committee.

NON-PUBLICATION OF MEDICARE MAXIMUM FEES

In June 1961, the General Accounting Office of the United States Treasury reported to Congress that in some states, physicians were abusing the Medicare program for financial gain. The "watchdog of the Treasury," as GAO is known, recommended that the Defense Department place strict controls on negotiations of fees and settlement of claims.

As a result, the following letter, quoted verbatim, was received from W. D. Graham, Brigadier General, MC, USA, Executive Officer of the Office for Dependents' Medical Care:

> "During the past several months, the Dependents' Medical Care Program policy concerning the publication of maximum allowable physician fees has received comment from several sources. This policy is that while we have always indicated a preference for non-publication of Medi-

care fees, the decision as to their publication in a particular state rests with the State Medical Society concerned. Basis for this position is that the Medicare Program should be consistent with medical administrative practices customarily followed in each particular state.

"The Committee on Appropriations, House of Representatives, in Report Number 574, 87th Congress, 1st Session, concerning the Department of Defense Appropriations Bill, 1962, commented in part on Dependents' Medical Care as follows:

'****, the Committee wished to call the attention of the program administrators to the recent General Accounting Office report which dealt with the matter of distribution of fee schedules for medical services. Some remedial action would appear imperative in the face of the facts of human nature—experience has taught many an administrator, in many varied fields of activity, that a published ceiling soon becomes an established floor.'

"The American Medical Association in a news release of 2 June, 1961 concerning their position on the publication of fee schedules stated, 'knowledge of a fee schedule would tend to make physicians use the maximum fees.' This was in response to a prior press report that the General Accounting Office had likewise commented upon the publication by some state of Medicare maximum allowances.

"In view of the above, it is now the policy of this office that the Dependents' Medical Care Program fees should no longer be published for distribution to physicians in any state or territory. In keeping with this revision of policy, all Medicare contract renewals effective on or after 1 October, 1961 will contain a clause substantially as follows:

'No party to this contract will publish for distribution to or distribute to physicians who may provide authorized care at Government expense to eligible dependents, any of the fees contained in Appendix D (Medicare Manual and Schedule of Allowances) and addenda thereto. If any queries are received by parties of this contract concerning the Medicare maximum fee(s) negotiated for services performed or to be performed, the questioner will be advised to charge his usual or normal fee for like services provided to an individual with an annual income of $4,500 or less. Preparation and distribution of any publication containing dollar amounts of fees are not allowable costs under this contract.'

"Comparable proposed contract modifications to current Medicare contracts in force will be forwarded to you under separate cover for your consideration and action.

"It is recognized that Medicare fees have always been published and distributed to practicing physicians in New Jersey. Non-distribution of fees should not pose a continuing problem, however, since the concept that, under Medicare, physicians bill their usual charges for like services furnished to individuals with annual incomes of $4500, is continued and remains a contract provision. To facilitate a full understanding of this matter and to provide for adequate dissemination of the policy change, copies of this letter should be distributed to all New Jersey physicians."

As directed by General Graham, this letter was distributed to the physicians of New Jersey, identified as Bulletin MSA-B-56.

CLAIMS FOR SERVICES RENDERED BY PHYSICIANS NOW DECEASED

Claims for services rendered by physicians or dentists now deceased, may be accepted and processed for payment when executed and submitted on the regular DA 1863-2 claim form, with but one exception; the claim form DA-1863-2 must be certified by the deceased physician's legal representative. Further detailed instructions were distributed to the physicians of New Jersey in Bulletin MSA-B-55 on July 31, 1961.

RELEASES TO THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Dissemination of information to the physicians of New Jersey concerning the following subjects, was accomplished by releases to THE JOURNAL:

Identification of Servicemen's Dependents (issue, June 1961)—Service dependents printed DD form 1173 (Uniformed Services Identification and Privilege Card) *must* bear a definite expiration date. Some identification cards have been presented bearing the word "Indefinite," in lieu of a definite expiration date; such identification cards are not acceptable for payment of Medicare claims.

Cardiac Catheterization (issue, November 1961)—Effective September 1, 1961, cardiac catheterization *on an inpatient basis*, was conconsidered authorized care whether or not the procedure is followed by definitive surgery.

Immunization for Poliomyelitis and Influenza (issue, December 1961)—Effective November 1, 1961, in keeping with current medical management of pregnancy, immunizations (parenterally administered) against poliomyelitis and influenza were authorized for benefits under the Dependents' Medical Care Program.

Physicians will be reimbursed at the rate of

$1.00 per injection for the *cost* of the vaccine; but separate payment for professional services in the administration of the vaccine is *not* authorized.

ADMINISTRATIVE EXPENSE

Period	Amount	Cost Per Case
Dec. 7, 1956 - June 30, 1957	$19,670	$11.44
July 1, 1957 - June 30, 1958	28,796	3.21
July 1, 1958 - June 30, 1959	31,983	3.77
July 1, 1959 - June 30, 1960	17,383	3.74
July 1, 1960 - June 30, 1961	17,448	3.39
	$115,280	

The above administrative expense data reflect the initial costs accrued in promulgating the program in New Jersey (contract negotiations, printing, distribution of manuals, and training), and the subsequent additional costs resulting in connection with printing and distribution of new manuals and schedules of allowances incurred by the curtailment of benefits in October 1958. The cost of $3.39 per case for the fiscal year ending June 30, 1961, was the lowest since the heavy volume year ending June 30, 1958. Estimates of expenses incurred for the remainder of the calendar year 1961 indicate a constant rate. In view of the extra activity in December, which left only 5 claims on hand at the end of the year, the cost per case of about $3.20 for the calendar year 1961 is anticipated.

EXAMINATION BY THE DEPARTMENT OF BANKING AND INSURANCE

In February 1951, the Secretary of the Board of Governors of Medical Service Administration of New Jersey communicated with the Department of Banking and Insurance, requesting that the Administration be relieved of filing a long form report, and also, be relieved of the regular official triennial examination with its attendant large fee, on the ground that Medical Service Administration was not engaged in any activity involving insurance risks.

In December 1951, the Department replied that it would be prepared to accept a simple statement of the activities of Medical Service Administration in lieu of the long form report.

In June 1958, the Department of Banking and Insurance informed Medical Service Administration that as a result of assuming the function of Fiscal Administrator for the Medicare Program, it would be required to file a financial report on the conventional long form again, commencing with the year 1957. The Department made a complete examination of Medical Service Administration for the seven-year period ending December 31, 1956, for which a bill in the amount of $782.03 was submitted.

Under date of December 30, 1960, the Medical Director submitted a letter of protest to the Department, outlining in detail the activities of the Administration, and requested reconsideration by the Department for payment of the $782.03.

On February 28, 1961 a letter was received from the Department of Banking and Insurance indicating that it was in agreement that there was no basis for either an official examination as to condition of the Administration, or for submission by the Administration of an Annual Statement to the Department of Banking and Insurance and, in consequence, it would not be necessary to pay the bill for $782.03 which had been previously presented to the Administration.

Medical Service Administration of New Jersey has repeatedly demonstrated its importance and value to the physicians of New Jersey. Its successful operation of the City of Newark Medical Plan on a municipal level, and the Medicare Program on a Federal level, amply supports its effectiveness as an arm of The Medical Society of New Jersey. As an agency by which payment for medical and surgical care may be made by arrangements with governmental agencies at Federal, State or other levels, to individuals and groups who might otherwise be unable to obtain protection against illnesses on a non-profit voluntary prepayment basis, Medical Service Administration has won the acceptance of the medical profession and the public which it serves. Moreover, it is designed to preserve and enhance the basic tenets which the medical profession has always insisted it shall retain—no interference in patient-physician relationship and free choice of physician and patient.

The Board of Governors of Medical Service Administration of New Jersey again wishes to express to The Medical Society of New Jersey its appreciation of and thanks for its continued interest in the affairs of the Administration, and for the financial support so generously given in the past.

Approved (page 442)

MEDICAL-SURGICAL PLAN OF NEW JERSEY

Royal A. Schaaf, M.D., President, Board of Trustees

(Reference Committee "C")

The facts and figures presented in the following pages reflect the major aspects of Medical-Surgical Plan's record of progress in 1961 —a year that saw new records established for benefits paid, for services rendered, for subscriber enrollment, and for participation by the physicians of New Jersey. In presenting this report to the members of the medical profession on behalf of the Plan's Board of Trustees and management, it is appropriate also that mention of further areas of progress achieved in the past year, be made.

In response to a growing desire on the part of the public for increased medical-surgical coverage, the Plan broadened its available benefits in several areas.

These included adoption of new codes and benefits covering open heart surgery and certain diagnostic pathological procedures. Eligible surgical diagnostic procedures were added. Coverage for diagnostic consultation services in certain critical conditions was increased. In cooperation with Hospital Service Plan of New Jersey, an optional joint rider was introduced for employed groups, covering various diagnostic, pathological and therapeutic services rendered either in physicians' offices or hospital out-patient departments.

Flexibility in meeting subscribers' needs was attained by special riders developed to conform to the national pattern of benefits required by members of the motor industry, and to provide additional benefits required for employees of the Federal Government.

A significant development during the year, which stemmed from constructive interest on the part of The Medical Society of New Jersey, was the retention by the Plan of its own Public Relations Officer, responsible to the Plan's chief executive officer and wholly recompensed by the Plan. The Plan appreciates the contribution by the Medical Society in this undertaking, which has led to excellent results. The new Public Relations structure has functioned admirably and has made itself a vital and effective arm of the Plan. While enjoying mutually cordial and cooperative relations with the Public Relations Office of Hospital Service Plan, it has maintained the autonomy which was sought in its creation.

A nominal rate increase granted the Plan early in the year became effective May 1, 1961. The effect of this during the balance of the year was to reduce slightly the underwriting loss incurred in 1960, but it was still necessary to invade Plan reserves in the amount of $1,651,811. The full gain in income to be realized from the rate increase will not be felt until after May 1, 1962, when the increase will have become effective on all subscription contracts. There is reason for cautious optimism that 1962 will see the recent years' losses appreciably reduced in amount.

On several occasions during the year, the Plan took forthright action to rally opposition to legislative proposals that were inimical to the free enterprise system of medical practice, and which would have endangered the protection afforded to more than two million New Jersey residents enrolled in the Plan.

It seems certain that the future will bring increasing demands for even broader benefits, for new service benefit income levels, and for full participation in national accounts. To keep abreast of the times and hold its position as the most effective provider of voluntary prepaid medical cost protection, Blue Shield must constantly explore new areas and methods of service. New enabling legislation may be necessary to make some of these goals possible in New Jersey.

With the continued fine support of The Medical Society of New Jersey, the loyal service of our Participating Physicians, the devoted and efficient work of our operating staff, and the cooperation of Hospital Service Plan of New Jersey, the Medical-Surgical Plan of New Jersey will meet the challenges of the future in its service to the public and to the medical profession.

MEDICAL-SURGICAL PLAN OF NEW JERSEY

COMPARATIVE STATEMENT

as of December 31, 1961

ASSETS

	1961	1960
Cash on Hand and in Banks (Working Funds	$ 95,071	$ 20,700
Investments	11,432,836	12,694,494
Accounts Receivable—Subscriptions	737,598	514,926
Accounts Receivable—Workmen's Compensation	26,862	37,521
Accounts Receivable—Hospital Service Plan	—	137,648
Accounts Receivable—Federal Employee Program	566,157	328,671
Accounts Receivable—Miscellaneous	774	939
Accrued Interest and Dividends Receivable	89,139	102,079
TOTAL ASSETS	$12,948,437	$13,836,978

LIABILITIES

Claims Outstanding:				
Reported	$2,051,000		$2,270,000	
Unreported	4,060,000	$ 6,111,000	3,330,000	$ 5,600,000
Unearned Subscriptions		1,353,751		1,247,535
Accounts Payable—Hospital Service Plan		84,427		—
Accounts Payable—Miscellaneous		166,070		104,443
TOTAL LIABILITIES		$ 7,715,248		$ 6,951,978

RESERVES

Securities Evaluation	$ 343,000	$ 380,000
Special Contingent	100,000	100,000
Unassigned	4,790,189	6,405,000
TOTAL RESERVES	$ 5,233,189	$ 6,885,000
TOTAL LIABILITIES AND RESERVES	$12,948,437	$13,846,978

TABLE I.

Paid 1961	Total Services	Per Cent All Services	Payment	Per Cent	Payment Per Service
Surgical	270,698	46.9%	$16,499,798	50.5%	$60.95
Medical	112,488	19.5	6,922,127	21.2	61.54
Obstetrical	47,447	8.2	6,093,769	18.6	128.43
Consultations	35,174	6.1	533,721	1.6	15.17
Anesthesia	111,579	19.3	2,649,470	8.1	23.75
TOTAL	577,386	100.0%	$32,698,885	100.0%	$56.63

TABLE II.

DISTRIBUTION OF RIDER A SERVICES AND PAYMENT

	Total Services	Per Cent All Services	Payment Amount	Payment Per Cent	Payment Per Service
Surgical	2,046	15.8%	$ 42,094	19.5%	$ 20.57
Medical	441	3.4	19,461	9.1	44.13
Diag. X-ray	5,916	45.6	101,201	47.1	17.11
X-ray Therapy	59	0.5	8,809	4.1	149.31
Isotope Therapy	9	0.1	420	0.2	46.67
Physical Therapy	582	4.5	15,001	7.0	25.77
Radium Therapy	16	0.1	1,127	0.5	70.43
Pathology	3,890	30.0	26,899	12.5	6.92
TOTAL	12,959	100.0%	$215,012	100.0%	$ 16.59

TABLE I excludes Federal Claims Data

FEDERAL EMPLOYEE PROGRAM

The Plan has participated in the underwriting of the Government-Wide Service Benefit Program for Federal Employees since its inception in July, 1960. Initially only basic benefit claims were serviced locally, and all supplemental benefits (major medical) claims were required to be sent to the Administrative Agency in Washington.

As of April, 1961, arrangements were concluded for the administration of the supplemental benefit claims as well by the Plan. This has resulted in better claim service for the Federal Employees in New Jersey, and has helped to emphasize this Plan's identification with the nation's largest health benefit program.

During 1961 the Plan paid over 22,000 cases under the Federal Employee Program. The following is the statement of income and expense:

Income	$1,995,360.01	100.0%
Claims Incurred	1,875,860.25	94.0
	$ 119,499.76	6.0%
Operating Expense	95,450.13	4.8
Gain	$ 24,049.63	1.2%

PAID BASIS

Average Exposure (Persons)	107,378
Claim Incidence per 1,000 Persons Enrolled	210
Average Cost per Case	$73.77
Number of Cases	22,568
Amount Paid	$1,664,860

TABLE III.

DISTRIBUTION OF EARNED SUBSCRIPTION INCOME

Earned Subscription Income	$36,183,635	100.0%
Incurred Claims	34,574,745	95.6
Operating Expense	3,269,835	9.0
Underwriting Loss	1,660,945	(4.6)

DISTRIBUTION PER DOLLAR OF INCOME

	Cents
Surgical	48.2
Medical	20.3
Obstetrical	17.8
Anesthesia	7.7
Consultations	1.6
Operating Expense	9.0
Total of above	104.6
Underwriting Loss	-4.6
	1.00

PHYSICIAN RELATIONS PROGRAM

Increased activity on all fronts of the Physician Relations Program in 1961 was reflected in a flow of information and assistance between the Plan and physicians that was wider in scope and greater in depth than in any previous year. While the increase was due in part to interest engendered by the issuance of special contracts and riders, much of it can be attributed to steadily growing appreciation and use of this avenue of cooperation.

Operations in the field, where matters of mutual interest are discussed in person with physicians and their office assistants, included contacts with 4,215 persons, 464 more than the preceding year. These were made through activities that included 84 hospital meetings, 6 more than in 1960, and at medical conventions, county medical society meetings, meetings with office assistants and visits to doctors' offices.

Services rendered from the Plan's headquarters also showed a marked increase. Assistance was given in response to a total of 6,263 incoming phone calls, 2,265 more than in the preceding year, while outgoing calls rose by 1,583 to a total of 6,518. In addition, 3,385 communications were received and handled.

Broadening of Plan benefits and the issuance of special contracts and riders were topics that caused much interest and evoked many inquiries on the part of the medical profession that were dealt with by Physician Relations. The areas most frequently touched upon were the General Provisions of the Plan's Schedule of Maximum Payments; rider coverage, and the Federal Employees Contract.

During the year, the number of Participating Physicians enrolled with the Plan was increased by 325 to a total of 6,564, highest membership in Plan history. This represents 81 per cent of all eligible physicians in New Jersey, and testifies to the continuing support and cooperation of the profession in the state.

During the coming years, as it has been in the past, the mission of Physician Relations will be to meet this support and cooperation with every effort to provide information and assistance to the physicians whose services make possible the Plan's benefits to the community.

Medical-Surgical Plan Public Relations assumed a new role in Plan operations during 1961. The scope of the program and communications media employed are shown below.

PUBLIC RELATIONS PROGRAM

Physicians:

- Medical Society Journal
  - News releases
  - Suggested editorials
  - Advertisements
- Newsletter (with Physician Relations)
- County Society publications
- Displays at conventions
- Literature
- Direct Correspondence
- Blue Shield Quiz
- Blue Shield Pulse
- Form Letters

Legislative:

To Legislators:
MSP position statements
To Physicians:
Mass mailings re: MSP position
To Public:
News releases re: MSP position

Subscribers:

Literature
"Fast Facts"
Direct Correspondence
Bill stuffers
Posters
Form letters

Public:

Newspapers
Business magazines
Union publications
Releases and features re: Plan actions, policies, and personel; Advertisements
House organs
Features on benefits received
Window displays

Enrollment:

Literature
Films
Posters
Advertising
Newspaper
Radio
Window Displays
Posters
Bus Cards

MSP Employees:

"Two Blues News"
Direct assistance in employee projects
Publicity on employees

Other Plans:

Direct Correspondence
Exchange of literature, information and ideas

Community Organizations:

Assisting health-oriented groups
Representing MSP at community functions
Serving as Red Cross Public Relations Chairman and Director
Arranging for Window Displays

The Medical-Surgical Public Relations Office also provided counsel to Plan Management and Trustees, and discharged administrative responsibility for creation, review and revision of Plan literature, publications, form letters and other printed material. Its functions are closely coordinated with those of Hospital Service Plan Public Relations.

HIGHLIGHTS OF 1961

Legislative Commission hearings on the administration and rate structure of the Plan ended early in the year.

A rate increase, averaging 15.7 per cent, was approved by the State Department of Banking and Insurance, effective with contract renewal dates on and after May 1, 1961.

New Jersey State Employees joined Medical-Surgical Plan and Hospital Service Plan, which were selected to provide the basic health benefits under a new State program enacted in 1961. Some 9,000 State employees, plus their dependents, were enrolled.

Broadened benefits were made available. Working in close collaboration with Hospital Service Plan, The Medical Society of New Jersey and the State Department of Banking and Insurance, the Plan joined with Hospital Service Plan in the introduction of Rider J, which provides to employed groups benefits for various diagnostic, pathological and therapeutic services rendered either in physicians' offices or hospital out-patient departments.

Great assistance was rendered to the Plan during the year by the newly constituted Advisory Committee to Review Medical-Surgical Plan and Hospital Service Plan Disputed Claims, organized by The Medical Society of New Jersey, which began functioning in January. The recommendations made by this professional body, operating as an "appeals court" unrelated to the Plan, were of immeasurable aid in achieving understanding and acceptance by subscribers and physicians in claim disputes.

An Integrated Data Processing System for maintenance of all subscribers' records on tape was instituted during the year. All group records were converted to tape by year's end, and conversion of direct payment records is well under way and will be completed in 1962.

CLAIMS INCURRED

Year	Amount
1942	$ 5,000
1945	208,000
1948	1,204,000
1951	6,527,000
1954	13,992,000
1956	18,961,000
1957	22,886,000
1958	25,038,000
1959	29,916,000
1960	31,516,000
1961	34,575,000

INCIDENCE RATE PER 1,000 PERSONS ENROLLED

Year	Incidence
1942	40
1945	86
1948	96
1951	112
1954	126
1956	143
1958	153
1959	165
1960	166
1961	177

ENROLLMENT GROWTH

Year	Enrollment
1942	4,131
1945	49,441
1948	236,604
1951	669,906
1954	1,196,804
1958	1,830,397
1960	2,080,582
1961	2,176,679

COMPARATIVE SUMMARY OF OPERATIONS

		1961	Per Cent		1960	Per Cent
Subscriptions Earned*		$36,183,635	100.0		$32,090,542	100.0
Less:						
Claims Incurred	$34,574,745**		95.6	$31,516,019		98.2
Operating Expenses	3,269,835***		9.0	2,777,374		8.7
		$37,844,580	104.6		34,293,393	106.9
(Loss) from Underwriting Operations		$(1,660,945	(4.6)		$(2,202,851)	(6.9)
Income on Investments		383,604			426,365	
Operating (Loss) for the Year		$(1,277,341)			$(1,776,486)	

* The gain of $3,097,733 in subscriptions earned (not including Federal Employee Contracts) reflects gains in enrollment, which increased by 96,097 during the year, and an average rate increase of 15.7 per cent that became effective with contracts having anniversary dates on and after May 1, 1961.

** The rise of $3,058,726 in claims incurred is attributable to increased exposure from larger enrollment and to increased incidence, which rose from 166 per 1,000 persons to 177.

*** The increase of $492,461 in operating expenses is caused by increased services rendered by Hospital Service Plan in the amount of $363,356 and a rise of $129,105 in Medical-Surgical Plan direct expenses. Based on subscriptions earned, total operating expense increased by three-tenths of one per cent.

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

Reserves at January 1	$ 6,885,000	$ 8,632,042
Operating (Loss) for the Year	(1,277,341)	(1,776,486)
	$ 5,607,659	$ 6,855,556
Plus (Minus): Change in Non-Admitted Assets	(374,470)	29,444
Reserves at December 31	$ 5,233,189*	$ 6,885,000

* The decrease of $1,651,811 in reserves for the protection of Plan subscribers is caused by a net operating loss of $1,277,341, plus downward reserve adjustments totaling $374,470.

PARTICIPATING AND NON-PARTICIPATING PHYSICIANS IN NEW JERSEY BY SPECIALTY

Specialty	Total Eligible Phys.	PARTICIPATING Total	M.D.	D.O.	D.S.C.	NON-PARTICIPATING Total	M.D.	D.O.	D.S.C.	% P.P. As of 12-31-61	% P.P. As of 12-31-60
1. Anes.	309	180	174	6		129	126	3		58.2	61.6
2. Derm.Syph.	113	94	93	1		19	19			83.2	83.9
3. Int. Med.	904	758	753	5		146	146			83.8	83.3
4. Neur. Surg.	28	17	17			11	11			60.7	57.1
5. Obst. Gyn.	498	260	258	2		238	238			52.2	49.1
6. Ophth.	243	185	183	2		58	58			76.1	77.7
7. Orth. Surg.	175	126	125	1		49	49			72.0	73.2
8. Otolar.	167	111	110	1		56	56			66.4	68.3
9. Path.	102	86	85	1		16	16			84.3	85.7
10. Ped.	406	372	371	1		34	34			91.6	89.8
11. Phys. Med.	11	8	8			3	3			72.7	80.0
12. Plast. Surg.	24	12	12			12	12			50.0	38.0
13. Prev. Med. & Pub. Health	4	3	3			1	1			75.0	75.0
14. Proct.	34	22	20	2		12	12			64.7	66.6
15. Psy & Neuro.	194	136	135	1		58	58			70.1	71.0
16. Radiology	158	126	122	4		32	32			79.7	82.3
17. Surgery	687	532	525	7		155	152	3		77.4	80.4
18. Thor. Surg.	18	8	8			10	10			44.4	38.8
19. Urology	148	80	79	1		68	68			54.0	59.5
20. Chiropody	349	343			343	6			6	98.2	98.5
21. General	3530	3105	2735	370		425	365	60		87.9	86.8
Total	8102	6564	5816	405	343	1538	1466	66	6	81.0	80.9

1961 BOARD OF TRUSTEES

Charles W. Barkhorn, M.D.	1952
Irving P. Borsher, M.D.	1950
F. Clyde Bowers, M.D.	1961
Robert G. Boyd	1957
Charles L. Cunniff, M.D.	1958
Andrew P. Dedick, Jr., M.D.	1961
Joseph P. Donnelly, M.D.	1953
Joseph I. Echikson, M.D.	1954
Jerome G. Kaufman, M.D.	1959
Joseph M. Keating, M.D.	1953
Samuel J. Lloyd, M.D.	1958
Arthur W. Lunn	1951
Paul Mecray, Jr., M.D.	1953
Duane E. Minard, Jr.	1957
Glennis S. Rickert, M.D.	1959
Royal A. Schaaf, M.D.	1942
Rudolph C. Schretzmann, M.D.	1945
James H. Spencer, M.D.	1957
Edward W. Sprague, M.D.	1942
John S. Thompson	1942
Thomas J. White, M.D.	1951
Gustave E. Wiedenmayer	1961

NOTE: Appointment Year Shown After Name.

† Deceased.

ADVISORS TO THE BOARD OF TRUSTEES

		Term as Board Members
Harry N. Comando, M.D.	1959	1942-1958
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952
Elton W. Lance, M.D.	1951	1942-1951

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.	1945-1945
†Theophilus H. Boysen, M.D.	1944-1945
Lewis W. Brown, M.D.	1949-1954
†William J. Carrington, M.D.	1942-1943
†Patrick H. Corrigan, M.D.	1952-1958
†Samuel A. Cosgrove, M.D.	1944-1953
William K. Harryman, M.D.	1944-1945
Sigurd W. Johnsen, M.D.	1950-1951
†Augustus S. Knight, M.D.	1942-1948
†Thomas K. Lewis, M.D.	1942-1949
†Norman M. Scott, M.D.	1942-1950
Reuben L. Sharp, M.D.	1950-1951
†Carl K. Withers	1952-1961

Approved (page 442)

REFERENCE COMMITTEE ON CONSTITUTION AND BYLAWS

ANDREW C. RUOFF, M.D., Chairman

The Reference Committee on Constitution and Bylaws met at 11:10 a.m., Sunday, May 13, 1962, at Haddon Hall, Atlantic City. The entire committee was present: Dr. Ruoff, chairman; Dr. Eynon, Dr. Smith, Dr. Stamps, and Dr. Zimmerman.

1. **Amendment to the Constitution** (page 409).

The reference committee **recommends** that the following proposed amendment to **Article IV** of the Constitution be adopted:

Current

Section 4 — Delegates

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Proposed

Section 4 — Delegates

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each twenty (20) members or major fraction thereof, unless otherwise stipulated by the House of Delegates in the interest of maintaining the total membership of the House so that it does not exceed four hundred (400) members, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office for each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Adopted

2. **Amendments to the Bylaws, Chapter IX—Administrative Councils and Committees** (page 409)

A. **Section 2, Qualifications, Selection and Terms of Members**

The reference committee **recommends** that the following proposed amendment be adopted:

Add the following paragraph:

(g) If a member of a council or committee, either appointed by the President or elected by the House of Delegates, absents himself from two consecutive meetings without excuse, it may be presumed that he has vacated his position on the council or committee, and the President may fill the vacancy until the next annual meeting.

Adopted

B. **Section 14—Committee on Medical Education**

The reference committee **recommends** that the following proposed amendment be adopted:

Add the following paragraph:

(c) This committee shall maintain an active interest in the continuing medical education of the members of this Society.

(d) This committee shall maintain a continuing interest in the intern and resident training program in the State.

Adopted

3. **Committee on Revision of Constitution and Bylaws** (page 384)

The committee accepted the report of the Committee on Revision of Constitution and Bylaws as presented, commends the committee for its work during the past year, and **recommends** that the report be approved.

Report adopted as a whole.

REFERENCE COMMITTEE "A"

Nicholas E. Marchione, M.D., Chairman

Reference Committee "A" met on Sunday, May 13, 1962, at 11:00 a.m. with all members present—Drs. Norman K. Boudwin, Burlington County; Thomas F. Flynn, Gloucester County; Matthew E. Boylan, Hudson County; Dorsett L. Spurgeon, Sussex County; and Nicholas E. Marchione of Cumberland County.

In addition to the committee, there were approximately 20 members present during the meeting to discuss the various reports.

1. **President** (page 348)

This report was carefully reviewed and approved by the reference committee. The committee took special note of the amount of work that the presidency involved, including the many meetings and many miles of travel and wishes to express its thanks to Dr. Ralph M. L. Buchanan for all the time and effort he has expended on behalf of the Society in this particularly trying year. We **recommend** approval of the report of the President.

Adopted

2. **Secretary** (page 349)

This report was thoroughly reviewed and approved. The committee commends Dr. Marcus H. Greifinger on the thoroughness and accuracy of his good work. We **recommend** approval of the Secretary's report.

Adopted

3. **Board of Trustees** (page 354)

The first portion of the report—that referred to Reference Committee "A"—covering highlights of the general activities of the Board during the year was reviewed in detail and approved. We **recommend** approval of this report.

Adopted

4. **Applications for Membership**

A. **Comment by Board of Trustees** (page 354)

The committee reviewed and discussed thoroughly and at length the report of the Board of Trustees concerning applications for membership. The committee **recommends** adoption of the report of the Board in this connection.

Adopted

B. **Resolution** #1 (page 410) from Hudson County

The committee thoroughly reviewed and discussed resolution #1 and **recommends** that it not be be approved in its present form, as written. Inasmuch as the Board of Trustees' report and resolution #1 are intimately tied together, it was the consensus of the reference committee that the entire problem be referred to the Committee on Revision of Constitution and Bylaws for timely changes in the method by which members are accepted or rejected into the component society and the parent Medical Society of New Jersey. The committee recognizes that, according to the present Constitution and Bylaws, the Credentials Committee at the present time can only approve or disapprove an application.

Adopted

5. **Credential Forms**—Comment by Board of Trustees (page 355); Resolution #2 (page 410) from Hudson County

The committee thoroughly reviewed and discussed the report of the Board of Trustees concerning Credential Forms and Resolution #2 from the Hudson County Medical Society on the same subject. The committee sympathizes with Hudson County concerning the amount of secretarial work involved in the repetition and duplication of forms, but feels that the interest of the Society would best be served by submission of the completed second application which is the decisive form involved in the admission to active membership.

Therefore, the committee **recommends** that the report of the Board of Trustees (page 355) be adopted, and that Resolution #2 (page 410) presented by the Hudson County Medical Society be rejected.

Adopted

6. **Executive Officer** (page 363)

This report was reviewed and approved. The only comment was made by Mr. Nevin, who contributed a correction in punctuation to his own report. The committee expresses its thanks to Mr. Nevin for his help and guidance to our committee, and compliments him on a well-presented and thought-provoking report.

Adopted

7. **Judicial Council** (page 365)

The report of the Judicial Council was considered in its entirety, and the reference committee weighed each individual section. The committee recognizes, with thanks, the amount of time and effort this Council has given to its work and commends the Council for an excellent and timely report.

The committee **recommends** adoption of this report.

Adopted

The committee extends its best wishes to Dr. Emanuel M. Satulsky as he relinquishes his position as Chairman of the Judicial Council in consequence of his election to the Board of Trustees, and is confident that the succeeding chairman of the Judicial Council will continue the good work of this group.

8. **Credentials Committee** (page 372)

This report was reviewed and approved. Your reference committee commends the Credentials Committee for its continued good work.

Adopted

9. **AMA Lists of Physicians—Resolution #10** (page 415) from Mercer County

This resolution was reviewed and discussed. The committee **recommends** that it be not adopted on grounds that it does not clearly state whether the list mentioned was the official directory of the AMA or a specialized list of names. The reference committee **recommends** that the resolution be called to the attention of the Board of Trustees and the delegates and alternate-delegates to the AMA, for further investigation and clarification.

Adopted

10. **AMA Delegates—Resolution #21** from Bergen County (page 422)

The reference committee reviewed and discussed resolution #21 concerning AMA delegates. It was the unanimous opinion of this reference committee that resolution #21 be rejected. The committee commends Bergen County for its splendid concern as to who are the official spokesmen of the Society on a national level, but **recommends** rejection of this resolution for the following reason: This action would be discriminatory against these delegates and their alternates insofar as no other nominated officer of the Society is required to make similar statements.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "B"

John B. Fuhrmann, M.D., Chairman

Reference Committee "B" met at 11:00 a.m., Sunday, May 13, 1962, with all members present: Dr. John B. Fuhrmann, Chairman, Hunterdon County; Dr. Charles A. Landshof, Hudson County; Dr. Jesse McCall, Sussex County; Dr. Reuben L. Sharp, Camden County; and Dr. John J. Torppey, Essex County. Also present and participating in the discussions were: Dr. Davidson, Essex County; Dr. Allman, Atlantic County; Dr. Heller, Bergen County; Dr. Graham, Passaic County; and Dr. Featherston, Monmouth County.

1. **AMEF—Resolution #3** (page 411) from Bergen County

This resolution was discussed, and we **recommend** its adoption.

Adopted

2. **Financial Reports—Resolution #4** (page 411)

With Dr. Heller, the proposer, in attendance, this resolution was discussed in length and detail. As is the prerogative of a reference committee, and with the complete agreement of Dr. Heller, certain minor changes were made in his resolution. We now **recommend** for adoption by the House of Delegates the following:

Be it resolved that:

(1) The House of Delegates continue to be presented with full yearly financial reports for their consideration.

(2) A signed statement defining the scope of the audit and a certification of the Treasurer's report be appended to each annual financial report.

(3) Methods of presentation of yearly reports be changed to facilitate full understanding.

(4) Our Treasurer and Trustees continue to use our capital funds in such a way as to obtain the largest return possible, consistent with the principles of prudence and safety.

Adopted

3. **Finance and Budget Committee** (page 374)

After lengthy discussion and answering of many questions, the reference committee **recommends** the following items:

(1) That the per capita level of contribution to AMA-ERF (American Medical Association - Education Research Foundation) for 1963 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Adopted

(NOTE: No action was taken by the House of Delegates to set the per capita level of conbution to AMA-ERF for 1963.)

(2) That the budget for 1962-63 be adopted in the total sum of $223,748.

Adopted

(3) That the 1963 assessment be adopted at $40 per capita, with no provision for a contribution to AMA-ERF.

Adopted

The first item in the Finance and Budget Committee report, namely THE JOURNAL, was discussed at some length; and it is the **recommendation** of the reference committee that the last sentence be deleted ("THE JOURNAL, except for salary items, will continue to operate on its advertising income."), and that the paragraph read: "No budget appropriation has been requested for the publication of THE JOURNAL, office expenses, and travel. The Committee on Publication is to be congratulated once more for its continued excellent financial status."

Adopted

It is the feeling of this committee that in future years, a complete financial statement of THE JOURNAL should be included in the Publication Committee's report.

4. **Treasurer** (page 350)

The report of our Treasurer was reviewed in detail. We note with approval, that the report covers a twelve-month period as has been previously suggested; and in a previous part of this report we have recommended that this be continued. We also note, with approval, the detailed accounting of the Medical Student Loan Fund and suggest that this be continued.

We **recommend** that the Treasurer's report be received and that we congratulate our Treasurer on his continued fine work.

Adopted

5. **Medical Student Loan Fund Committee** (page 381)

The reference committee notes, with pleasure, the progress that the Medical Student Loan Fund Committee, under the able leadership of Dr. Luke A. Mulligan, is making. We also note the long list of private donors to the fund and that the recipients came from fourteen counties and attended fourteen different medical schools. We **recommend** the approval of the report.

Adopted

6. **Publication Committee** (page 383)

The Publication Committee's report was reviewed. We would like to commend the committee for its continued good work and for the quality of THE JOURNAL which it publishes. We **recommend** the approval of this report.

Adopted

In addition, it is the **recommendation** of the reference committee that the Publication Committee, in future years, make a complete financial statement as part of its report.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "C"

Kenneth E. Gardner, M.D., Chairman

Reference Committee "C" met at 11:00 a.m., Sunday, May 13, 1962. Present were: Dr. Johnson, Dr. Kinczel, Dr. Campo, Dr. Murphy, and your chairman.

1. **Distinction Between Blue Cross and Blue Shield —Resolution #9** (page 415)

In conference with representatives of Blue Shield, the committee was advised that a separate covering notice, explaining the difference in rates between Blue Cross and Blue Shield, could be included with the billing form sent to the subscriber.

The reference committee approved resolution #9 as submitted, and **recommends** its approval by the House.

Adopted

2. **HSP Maternity Benefits** (page 356)

A representative from Blue Cross advised the committee that a special contract with a separate premium will be available approximately September 1, 1962, and will include 14 additional days for post-partum, non-surgical complications.

The committee approved the increase in maternity benefits and the report from the Board of Trustees, and **recommends** that this item be approved.

Adopted

3. **Joint MSP-HSP Rider** (page 356)

The committee **recommends** approval of the action of the Board of Trustees. The committee notes that at present 118,000 persons are now covered, and that 77 claims have been paid under HSP outpatient department benefits, and 1177 under Blue Shield benefits. The average in other states is approximately three to one in favor of Blue Shield. Since the private physician controls the referrals it is **recommended** that he use other private physicians and their facilities whenever possible.

Adopted

4. **Medical Service Administration**

A. **Annual Report** (page 425)

The committee reviewed the report of the Medical Service Administration. MSA is well administered and deserves the commendation of this Society for the successful operation of the City of Newark's medical plan, and the Medicare Program. We **recommend** that this report be approved.

Adopted

B. **Board of Governors** (page 357)

The nominations for the Board of Governors of Medical Service Administration were approved:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

We **recommend** that the nominations be approved by the House.

Adopted

5. **Medicare Program** (page 356)

The committee received and approved the report on the Medicare Program, and **recommends** its approval by the House.

The committee noted that the 1962-63 contracts are in the process of being negotiated.

Adopted

6. **Medical-Surgical Plan**

A. **Annual Report** (page 430)

The report of Medical-Surgical Plan was received and approved. The committee reviewed the report and found the Plan to be progessive, aware of current problems, and well administered. Some of the major aspects of the report show new records for benefits established, higher subscriber enrollment, and greater participation by the physicians of New Jersey.

In cooperation with Hospital Service Plan an optional joint rider was introduced for employed groups covering various diagnostic, pathological, and therapeutic services rendered either in the physician's office or hospital outpatient department. Special riders were developed for the benefit of the automotive industry and employees of the Federal Government. The committee noted that the Plan has retained its own Public Relations officer.

A nominal rate increase became effective May 1, 1961.

To maintain its position as the most effective provider of voluntary prepayment medical costs, Blue Shield is constantly exploring new areas and methods of service . . . We **recommend** approval of this report.

Adopted

E. **Revision of Bylaws** (page 358)

The revision of the Bylaws was approved, including the amendments proposed by the MSNJ Board of Trustees. We **recommend** approval of this item

Adopted

C. **Board of Trustees** (page 359)

The committee reviewed and approved the nominations for the Board of Trustees of Medical-Surgical Plan:

One Year Term — 1962-63

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
F. Clyde Bowers, M.D.
Robert G. Boyd
Charles L. Cuniff, M.D.
Andrew P. Dedick, Jr., M.D.
Gustave E. Wiedenmayer
Louis S. Wegryn, M.D. (President, MSNJ)

Two Year Term — 1962-64

Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Jerome G. Kaufman, M.D.
Joseph M. Keating, M.D.
Elton W. Lance, M.D.
Samuel J. Lloyd, M.D.
Jesse McCall, M.D.

Three Year Term — 1962-65

Duane E. Minard, Jr.
Glennis S. Rickert, M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
David L. Yunich

The committee noted that physicians from South Jersey were not on the list and only one general practitioner was listed.

We **recommend** that the list of nominees as submitted be approved; and we further **recommend** that physicians from South Jersey and general practitioners be included in future lists of nominees.

Adopted

D. **Out-Patient Service** (page 358)

This item was reviewed and accepted by the committee, and we **recommend** that it be approved by the House.

Adopted

7. **National Blue Shield Senior Citizens Program** (page 357)

Although this is a national program, each state will determine its individual costs for those subscribers over 65 years of age with limited total income.

We **recommend** approval of the action of the Board of Trustees.

Adopted

8. **Basic Minimum Hospital and Home Care Plan—Resolution #23** (page 423)

This resolution was reviewed and due to its wide scope, we **recommend** that it be referred to the Board of Trustees for study and action, and that the Board report the results of its study and action at the next annual meeting.

Adopted

9. **HSP In-Patient Tests—Resolution #12** (page 417) from Camden County

Discussion of this resolution revealed that there is greater need for understanding of the provisions of the Blue Cross contract by both the patient and the physician, and that the physician should discuss the contract limitations with the patient where diagnostic procedures are anticipated which might not be covered by the contract *before* the examinations and services are ordered.

We **recommend** approval of the resolution, and urge that physicians discuss the Blue Cross contract limitations with their patients *before* ordering examinations and services.

Adopted

10. **Home and/or Nursing Care Under Blue Shield —Resolution #22** (page 422)

This resolution was approved by the committee. Blue Shield is now studying a program to implement a pilot study for Home and Nursing Care.

We **recommend** approval of the resolution, and further **recommend** continuation of the study by Blue Shield.

Adopted

My thanks to the members of the committee and to the representatives of Medical-Surgical Plan and Hospital Service Plan for their helpful suggestions and discussions.

Report adopted as a whole

REFERENCE COMMITTEE "D"

William J. D'Elia, M.D., Chairman

Reference Committee "D" met at 11:00 a.m., May 13, 1962. Present were: John E. McWhorter, M.D., Robert H. Areson, M.D., Samuel M. Diskan, M.D., Eugene J. Tyrell, M.D. and William J. D'Elia, M.D., chairman. Various members of the Society were present and participated in the discussions of the reports from: the Board of Trustees on Major Medical Insurance, Medical Defense and Insurance Committee, Medical Education Committee, Physicians Placement Service, and Retirement Plan for Physicians Committee.

1. **Major Medical Insurance** (pages 359 and 379)

"It was recommended last year by the Committee on Medical Defense and Insurance that the House adopt the proposal of the National Casualty Company for major medical insurance with $500 deductible, and that the E. & W. Blanksteen Agency be approved as the official brokers for this program. The House referred this item to the Board of Trustees for study and action."

This policy was approved by the Board of Trustees in July 1961—and members of the Society are presently being enrolled.

The reports on Major Medical Insurance, as contained in the annual reports, were approved.

Adopted

2. **Medical Defense and Insurance Committee** (page 377)

A. **Professional Liability**

The report on the present status and activities of the professional liability program is noted, with particular attention to the necessity for an increase in premium rates. In accordance with the original agreement, American Mutual will follow the National Bureau rates until it has creditable experience on its own.

The reference committee **recommends** adoption of this portion of the report, with a further **recommendation**: that the Loss Control Committee consist of 9 to 12 members and, when necessary, include seasoned individuals from other specialties on temporary membership, only for specific instances.

Adopted

B. **Premises Liability**

The report on Premises Liability was noted and approved.

Adopted

C. **Accident and Health**

The report on Accident and Health, including the Extended Professional Disability Policy, was noted and approved.

Adopted

D. **Life Insurance**

The report on the life insurance program covering acceptable and impaired risks was noted and approved.

Adopted

E. **Recommendations of Committee**

The reference committee **recommends** approval of the following recommendations of the Committee on Medical Defense and Insurance:

(1) That the contract with the American Mutual Liability Insurance Company for the professional liability insurance program be continued.

Adopted

(2) That the services of E. & W. Blanksteen Agency be continued as the Society's official broker for the accident and health, major medical expense, and life insurance programs.

Adopted

The reference committee wishes at this time to thank Dr. Featherston and the members of the Committee on Medical Defense and Insurance who attended the committee meeting, for their valuable help in arriving at our decisions.

The committee notes that there is low percentage of participation in the overall insurance program in various counties, and **recommends** that component societies give their complete support to these various programs.

Adopted

3. **Medical Education Committee** (page 380)

The reference committee agrees with the report of the Medical Education Committee and **recommends** its approval.

Adopted

4. **Physicians Placement Service** (page 387)

The reference committee compliments the Physicians Placement Service for its continued good work, and **recommends** the approval of the committee report.

Adopted

5. **Retirement Plan for Physicians Committee** (page 388)

The committee agrees with the a tion on a retirement program at state level. The committee also notes the comment of the Society's legal counsel re Senate Bill 32.

The reference committee **recommends** that the state committee continue to investigate actively all possible avenues of programming retirement plans at state and local level in addition to national level.

Adopted

6. **Interns Resolution #11** (page 416) from Camden County

The committee **recommends** that the resolution be **amended** to read:

> Resolved, that The Medical Society of New Jersey direct its delegates to the American Medical Association to recommend that the Association be made aware of the dangers to the medical graduates and to the community hospitals *and to the public at large* of the present practices of the medical centers to bring pressure on the medical graduates to intern in the medical centers, and that the Association take the necessary steps to encourage the medical graduate to seek his internship in his own community hospital.

and that the amended resolution be approved.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "E"

George L. Nicoll, M.D., Chairman

Reference Committee "E" met at 11:00 a.m., May 13, 1962, with all members present: Drs. Sherman Garrison, George E. Barbour, Charles L. Cunniff, James H. Spillane, and George L. Nicoll, chairman.

1. **AMPAC** (page 360)

The committee approved this item as submitted.

Adopted

2. **Council on Legislation** (pages 390 and 394)

These reports were reviewed, and the committee **recommends** approval of them as submitted. Special note is made of Doctor Buchanan's message to the New Jersey Legislature concerning A-755, and the committee commends him for his prompt action.

Special note also is made of S-264 and A-678, and the committee approves the position of "active opposition."

Adopted

3. **Senate Bill 142** (page 360) **and Resolution #8** (page 414)

Your committee, after careful study of the circumstances centering about S-142 and the Society's position of "no action" concerning it, is of the opinion that opposition to S-142 is tantamount to declaring that the Society does not approve the referral by physicians to lay-directed bioanalytical laboratories, and that—in consequence—the great majority of referrals will inevitably be sent to laboratories in connection with hospitals.

Conscious of the frequently expressed attitude of this House not to encourage the further invasion by hospitals in the practice of medicine, your committee **recommends** the approval of the action taken by the Board of Trustees in assuming the position of "no action" with reference to this measure. In doing so, your committee appreciates that the position of "no action" is based upon the desire of The Medical Society of New Jersey not to put itself diametrically in opposition to the position of "disapproval" as indicated by Medical-Surgical Plan of New Jersey.

Your reference committee, after giving careful consideration to this matter, feels that basic considerations would demand "approval" of S-142. The committee recognized the facts relating to this situation as set forth in the explanation supplied by the Board of Trustees, and feels that the Board took the only available and appropriate position.

Therefore, your reference committee **recommends** that Resolution #8 be disapproved.

Adopted by split vote, 190-135

4. **Council on Public Relations** (page 397)

The committee **recommends** approval of this report of the Council on Public Relations.

Adopted

5. **Medical Care Under Social Security**

In consequence of discussion from the floor of the reference committee, your committee takes this occasion to point out that the term "medicare" or "medical care" is a misnomer as applied to the proposed "hospital-nursing care" tax programs under Social Security. Legislation of this type makes no provision for the rendering of professional care by physicians or surgeons.

Amended to read: In consequence of discussion from the floor of the reference committee, your committee takes this occasion to point out that the term "Medicare" or "Medical Care" is a misnomer for what is actually a proposed "Hospital-Nursing Care" tax program under Social Security. (Last sentence deleted)

Adopted as amended.

Several resolutions and the supplemental report of the Board of Trustees were concerned with this area and were discussed at great length, with some 65 discussants.

A. **Board of Trustees—Supplemental Report** (page 361)

Your committee **recommends** conformity with the suggestions contained in the supplemental report of the Board of Trustees that the official position of The Medical Society of New Jersey concerning HR 4222—or any similar legislation—as submitted by President Buchanan to the House Ways and Means Committee, under date of July 6, 1961, be at this time reaffirmed. It follows:

Amended to include words "King-Anderson Bill," before "HR 4222"

Adopted as amended.

The Medical Society of New Jersey—in common not only with other members of the medical profession but with all who are dedicated to the preservation of a sound character in our people and in our nation and to the maintenance of a sound and well-balanced national economy—is "for":

1) The retention by the individual citizen—and of that citizen's family—of responsibility for selecting, arranging, and paying for his own necessary health care.

Amended to read: The retention by the individual citizen—and of that citizen's family—of the responsibility and the right for selecting, arranging, and paying for his own necessary health care.

Adopted as amended.

2) The limitation of tax burdens upon the individual citizen and his family so as to leave to them the financial means of meeting this responsibility.

3) The development and widespread utilization of adequate and economical private voluntary health insurance coverages as the best means of enabling such individual citizen and his family to meet this responsibility.

4) The intervention of government to assist only those citizens who need health care and are themselves demonstrably incapable of meeting the costs for it.

5) The maintenance of a minimum of federal governmental intervention and control. We hold that the assignment of responsibility for financing necessary health care should be in the following order: the individual citizen; the family; local voluntary agencies; local, county, state, and federal government . . . each to take over only when the prior agent of responsibility cannot meet the need. Because of this point of view we support the principle of the Kerr-Mills law as essentially preferable to the principle of HR 4222 and all like legislation.

Amended to include words "King-Anderson Bill," before "HR 4222"

Adopted as amended.

In consequence of what it is "for," The Medical Society of New Jersey is necessarily "against";

1) Any policy or program that would relieve or wrest from the individual and the family the right and responsibility to be independent, self-sustaining, self-reliant, and free.

2) Any policy or program that would so multiply burdensome taxes upon the individual citizen and his family as to deprive them of the financial means to retain and exercise those four fundamental rights and responsibilities.

3) Any policy or program that would encourage government, at any level, to eliminate or supplant voluntary free enterprise systems of insurance coverage, or of any other fundamental business or service operation.

4) Any policy or program that would enlarge for government, at any level, entrance into and influence over the lives, rights, and duties of individual citizens . . . in short, any policy or program that would give to government the control and direction of the lives of citizens instead of reserving to citizens the control and direction of their government.

Item adopted as amended

Your committee further **recommends** that The Medical Society of New Jersey officially record its recognition of the right of its members to hold and express views and opinions relating to the conditions under which they will practice medicine for the greatest benefit of their patients, but as

an organization The Medical Society of New Jersey is not involved in, or responsible for, their individual points of view.

Adopted

The Medical Society of New Jersey considers it sufficient to point out that just as, since 1766, its members have supplied the best possible medical care to the people of New Jersey, so they will continue to do. The Society adds this assurance—in reaffirmation of its frequently declared policy—"No one in New Jersey will be denied necessary medical care because of inability to pay."

Adopted

Further, the reference committee **recommends** that The Medical Society of New Jersey affirm that, as loyal citizens of this nation, its members will continue to provide the best possible medical care within the framework of the laws of the State of New Jersey and of the nation.

Adopted

Your reference committee also **recommends** that the House authorize the Board of Trustees to appoint an official committee to meet with the Governor of New Jersey and/or other duly constituted authorities, to clarify the Society's policies and position.

Adopted

It is the opinion of your committee that under any system of governmentally controlled medicine —as the experience of other countries amply demonstrates—the quality of medical care inevitably deteriorates; and for this reason, as well as for the other reasons already enumerated, as physicians we strongly oppose any legislation that would bring about such governmental control.

Substituted by: It is the opinion of your committee that The Medical Society of New Jersey should reaffirm its conviction that the continuing expansion, perfecting, and implementation of prepaid voluntary insurance plans, and the implementation of existing national legislation as exemplified by the Kerr-Mills Law, be supported and would be in the best interest of making such care as we desire available to all the citizens. Further, that it reaffirms its continuing opposition to such legislation as exemplified by HR 4222, the King-Anderson bill, which it is convinced would lead to the deterioration of the quality of medical care by the additional imposition of federal governmental controls.

Substitute adopted

B. **Resolutions #5** (page 412), from Union County, **#6** (page 413) from Monmouth County, and **#16** (page 419)

In view of the action of the House of Delegates in conjunction with the foregoing supplemental report of the Board, your committee **recommends** that Resolutions #5, #6, and #16—all of which are related to the subject matter dealt and disposed by the supplemental report of the Board—be not approved.

Adopted

6. **Public Educational Program—Resolution #13** (page 417) from Hudson County

Your committee agrees with the spirit and intent of Resolution #13, but suggests that it **be not** formally **adopted** by this House, but referred to the Board of Trustees and the Council on Public Relations for study and implementation.

Adopted

7. **Kerr-Mills Legislation—Resolution #14** (page 418) from Mercer County **and Resolution #19** (page 421) from Gloucester County

In view of the fact that the intent of these resolutions is basically a reaffirmation of a position already taken by this Society and is completely compatible with the attitude of the Society in endorsing the principle of the Kerr-Mills law in preference to the proposed King-Anderson-type legislation, your committee **recommends** the adoption of both of these resolutions and their referral to the Board of Trustees for any possible implementation.

Adopted

8. **Public Statements—Resolution #15** (page 418)

Your committee is of the opinion that the Society's record of achievement in this area does not support the implications of this resolution. The committee reposes confidence in its Council on Public Relations and the President of The Medical Society of New Jersey as spokesmen for this Society, and feels that the balanced mechanism presently in effect is properly less dangerous to the adequate representation of the Society's position than to hurried issuance of statements in this regard.

The committee, therefore, **recommends** that Resolution #15 be disapproved.

Adopted

9. **New Jersey Assembly Resolution—Resolution #20** (page 421)

The committee agrees with the spirit and language of this resolution and **recommends** its adoption.

Second paragraph of resolution amended to read: Whereas, It is reported that the Assembly of the State of New Jersey . . .

Adopted as amended

* * *

The chairman is very grateful for the indefatigable services of the members of his committee and all those who participated in the discussion and assisted it in clarifying the various aspects of all the matters considered.

Report as amended adopted as a whole

REFERENCE COMMITTEE "F"

David Eckstein, M.D., Chairman

Reference Committee "F", which concerns itself with medical services, industrial health, and workmen's compensation, met Sunday, May 13, 1962, in room 1335, Haddon Hall, Atlantic City, at 11:00 a.m., and adjourned at 1:25 p.m. All members were present: Dr. Eckstein, chairman; Dr. DeCecio, Dr. Brindle, Dr. Albano, and Dr. Weinstein.

1. **Ambulatory Patients** (page 360)

The committee approved the action of the Board of Trustees in reference to ambulatory patients and **recommends** meticulous observance of the action and encourages continued emphasis of the principles involved.

Adopted

2. **Intravenous Therapy by Nurses—Resolution #18** (page 420)

Your reference committee unanimously approved this resolution, and **recommends** its acceptance.

Adopted

3. **Medical-Legal Testimony** (page 361)

The committee approved the report on Medical-Legal Testimony by the Board of Trustees and commends those concerned in effectuating an idea which has long been on the planning boards.

We **recommend** approval of this report.

Adopted

4. **Council on Medical Services** (page 395)

Each item of the report of the Council on Medical Services was thoroughly discussed, and we **recommend** approval both of the report of the council and the action of the Board of Trustees. Furthermore, the committee **recommends** that the threat of corporate practice of medicine by hospitals be vigilantly and diligently met. In addition, the reports of the Committees on *Industrial Health* (page 399) and *Workmen's Compensation* (page 400) were approved as submitted. We commend the council and its special committees for their untiring efforts, and **recommend** adoption of their reports.

Adopted

5. **Proposed Relative Value Index for New Jersey** (page 361)

The reference committee considered the advantages and disadvantages of the proposed RVI, and heard opinions from all interested parties. In addition, the committee reviewed the supplemental report of the RVI mail poll.

Because of the lack of a clear-cut expression both by the poll and by the discussors before the reference committee, the committee makes no recommendation for or against the RVI, but submits the question to the House of Delegates for immediate vote.

Tabled

6. **Vendor Payments in Welfare Cases—Resolution #7** (page 413) from Burlington County

The committee unanimously approved the resolution proposed by Burlington County and takes note of a meeting recently held by a subcommittee of the Council on Medical Services and representatives of the State Division of Welfare in which this resolution was unanimously approved. We **recommend** approval of the resolution and continued activity of this subcommittee to effectuate the intent of the resolution.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "G"

John L. Olpp, M.D., Chairman

Reference Committee "G" met at 11:05 a.m. on May 13, 1962, with all members present. A number of delegates and special committee chairmen attended the meeting and discussed various reports.

1. **Council on Public Health** (page 396)

The report submitted by the Council on Public Health was approved, and the council is to be commended for the projects undertaken and completed.

Adopted

2. **Special Committees to the Council on Public Health**

The reports of the special committees to the Administrative Council on Public Health were discussed and the following **recommendations** are made:

A. **Cancer Control** (page 401)

The report of the Special Committee on Cancer Control was approved as submitted. The committee is encouraged to continue its efforts to have a tumor registry established in every hospital in the State of New Jersey.

Adopted

B. **Child Health** (page 401)

The report of the Special Committee on Child Health was approved as submitted. The opinion of the committee on the value of the Mantoux and Tine Tests was clarified by Dr. Jennings.

Adopted

C. **Chronically Ill and the Aging** (page 402)

The report of the Special Committee on the Chronically Ill and the Aging was considered and, after considerable discussion, was approved except for the recommendation: "that the State Society provide secretarial help when needed to give liaison between the State and County committees." This recommendation was disapproved because the reference committee feels there is considerable overlap between the activities of this committee and that of the Special Committee on Rehabilitation, which report was discussed concurrently.

The reference committee, after reviewing the reports of the Special Committees on the Chronically Ill and the Aging and on Rehabilitation, **recommends** that the activities of these two committees be coordinated in order to avoid duplication of effort and cost toward establishing and maintaining a directory of rehabilitative services.

It was further **recommended** that the aid of the New Jersey State Department of Health be enlisted to initiate and undertake this statewide project.

Adopted

D. **Rehabilitation** (page 407)

The report of the Special Committee on Rehabilitation was considered and approved with the exception of the recommendation: "That The Medical Society of New Jersey allocate $7,000 toward the initiation of the compilation of a directory of rehabilitation facilities in New Jersey—representing an approximate contribution of one dollar per member—toward the furnishing of a copy of the completed directory to each member," which was disapproved for the reasons given in the report of the Special Committee on the Chronically Ill and the Aging.

Adopted

E. **Conservation of Hearing and Speech** (page 404)

The report of the Special Committee on the Conservation of Hearing and Speech was approved as submitted.

Adopted

F. **Conservation of Vision** (page 405)

The report of the Special Committee on the Conservation of Vision was discussed and several items were clarified by Dr. Samuel Diskan. The report was approved as submitted, and ophthalmologists should be encouraged to schedule the workshops on "Eye Care for School Children."

Adopted

G. **Maternal and Infant Welfare** (page 406)

The report of the Special Committee on Maternal and Infant Welfare was approved as submitted.

Adopted

H. **Mental Health** (page 407)

The report of the Special Committee on Mental Health was approved as submitted, with the **recommendation** that the efforts of this committee to stimulate statewide interest in a privileged communication act be continued.

Adopted

Report adopted as a whole

REFERENCE COMMITTEE "H"

Frederick G. Dilger, M.D., Chairman

Reference Committee "H" met on Sunday, May 13, 1962, at 11:00 a.m. The following members were present: Drs. Donald T. Akey, Harry W. Fullerton, Jr., Nicholas G. Demy, Nathan J. Plavin, and Frederick G. Dilger, chairman.

1. **Traffic Safety** (page 389)

The committee considered the report of the Committee on Traffic Safety, and commends the members of that committee for an excellent job.

The reference committee **recommends** that the members of The Medical Society of New Jersey add practice to precept and have their own cars equipped with the safety devices recommended. The committee recommends approval of this report.

Adopted

2. **Nursing Education** (page 386)

The committee considered the report of the Committee on Nursing Education and approved it. The committee had the advantage of amplification of this report by its chairman, Dr. Levitas, and was much impressed by the pioneering and results already obtained by this committee.

Adopted

3. **Annual Meeting** (page 370)

The reference committee approved the report of the Committee on Annual Meeting, including the **recommendation**: "that the 200th annual meeting be held at Haddon Hall, Atlantic City—Saturday-Wednesday, May 14-18, 1966."

Adopted

4. **Scientific Exhibits** (page 371)

This committee approves the report of the Subcommittee on Scientific Exhibits.

Adopted

5. **Scientific Program** (page 371)

This committee approves the report of the Subcommittee on Scientific Program, and wishes to congratulate that committee for the excellence of its program.

Adopted

6. **Woman's Auxiliary Advisory** (page 385)

The reference committee approves the report of the Advisory Committee to the Woman's Auxiliary, and wishes to commend the Auxiliary without whose help the Society would be in dire straits.

Adopted

7. **Honorary Membership** (page 376)

This committee approves the report of the Committee on Honorary Membership.

Adopted

8. **Nominations for Emeritus Membership** (page 385)

The reference committee approves the nominations for emeritus membership as printed in the annual reports and in the supplemental report.

Adopted

Report adopted as a whole

PUBLIC INFORMATION

From the third session of the House of Delegates:

Motion from the floor, seconded, and **carried:**

That, in order to provide adequate and complete information to the public concerning the policies adopted by The Medical Society of New Jersey at this convention, the Board of Trustees be empowered and urged to purchase newspaper space or other means of disseminating public information within their discretion and judgment if the actions of this convention are not favorably presented.

REPORT OF THE NOMINATING COMMITTEE AND ELECTION

May 13, 1962

Office	*Term*	*From*	*To*	*Nominee*
President-Elect	1 year	May 1962	May 1963	Jerome G. Kaufman, M.D. Essex County
First Vice-President	1 year	May 1962	May 1963	Charles H. Calvin, M.D. Middlesex County
Second Vice-President	1 year	May 1962	May 1963	John J. Bedrick, M.D. Hudson County
Secretary	1 year	May 1962	May 1963	Marcus H. Greifinger, M.D. Essex County
Treasurer	1 year	May 1962	May 1963	Daniel F. Featherston, M.D. Monmouth County
Trustees:				
1st District	3 years	May 1962	May 1965	Nicholas A. Bertha, M.D. Morris County
	2 years (to fill unexpired term of Dr. Kaufman)	May 1962	May 1964	*Emanuel M. Satulsky, M.D. Union County
2nd District	1 year (to fill unexpired term of Dr. Bedrick)	May 1962	May 1963	*Joseph P. Donnelly, M.D. Hudson County
3rd District	3 years	May 1962	May 1965	Lloyd A. Hamilton, M.D. Hunterdon County
5th District	3 years	May 1962	May 1965	Carl N. Ware, M.D. Cumberland County
11th Trustee	3 years	May 1962	May 1965	Thomas C. DeCecio, M.D. Bergen County
Judicial Councilors:				
1st District	1 year (to fill unexpired term of Dr. Satulsky)	May 1962	May 1963	*Henry L. Hermann, M.D. Warren County
2nd District	3 years	May 1962	May 1965	John L. Olpp, M.D. Bergen County
5th District	3 years	May 1962	May 1965	Isaac N. Patterson, M.D. Gloucester County
AMA Delegates:				
	2 years	Jan. 1963	Dec. 1964	C. Byron Blaisdell, M.D. Monmouth County
	2 years	Jan. 1963	Dec. 1964	Luke A. Mulligan, M.D. Bergen County
	2 years	Jan. 1963	Dec. 1964	Joseph P. Donnelly, M.D. Hudson County
	2 years	Jan. 1963	Dec. 1964	Marcus H. Greifinger, M.D. Essex County
AMA Alternates:				
	2 years	Jan. 1963	Dec. 1964	F. Clyde Bowers, M.D. Morris County
	2 years	Jan. 1963	Dec. 1964	John F. Kustrup, M.D. Mercer County
	2 years	Jan. 1963	Dec. 1964	Joseph R. Jehl, M.D. Passaic County
	2 years	Jan. 1963	Dec. 1964	Frank J. Hughes, M.D. Camden County

Delegates and Alternates to Other States:

New York					
Delegate	1 year	1963	Convention		William F. Costello, M.D. Morris County
Alternate	1 year	1963	Convention		G. Ruffin Stamps, M.D. Atlantic County
Connecticut					
Delegate	1 year	1963	Convention		Lloyd A. Hamilton, M.D. Hunterdon County
Alternate	1 year	1963	Convention		S. Eugene Dalton, M.D. Atlantic County

Administrative Councils:

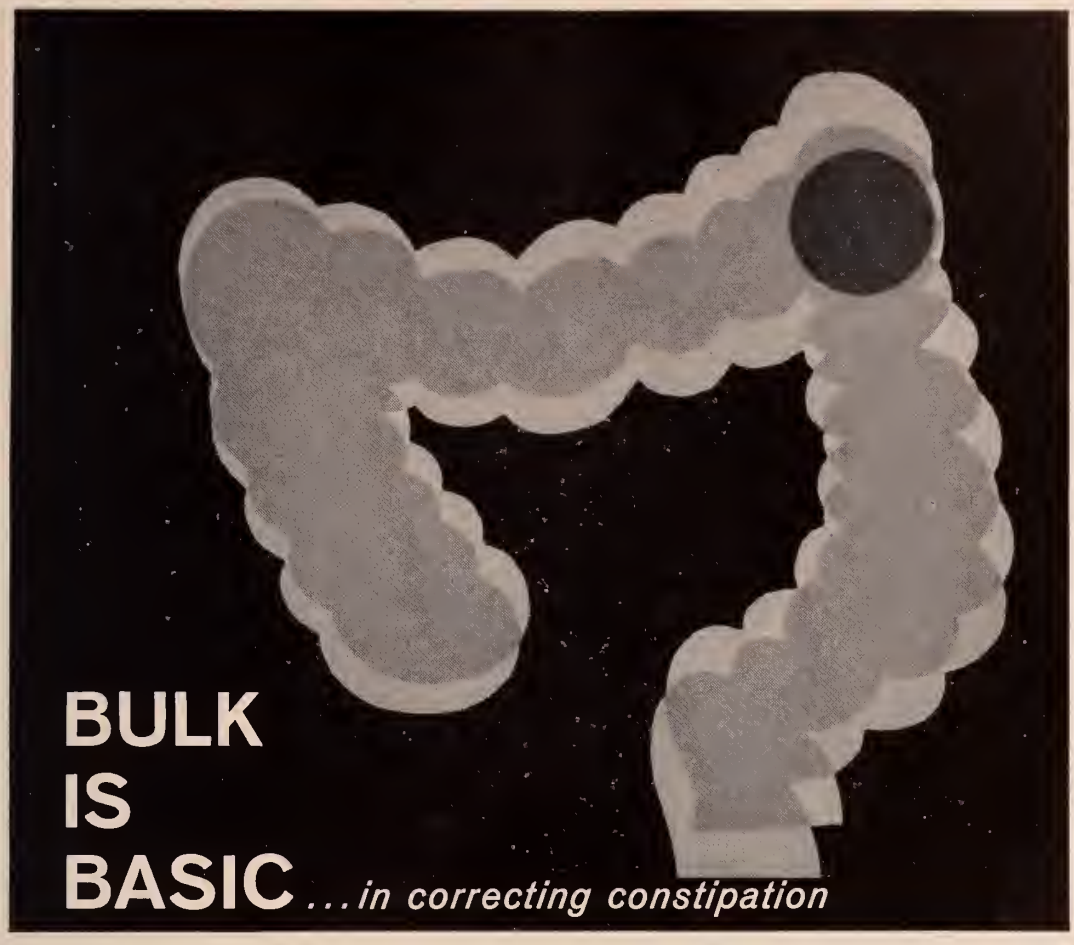
Legislation					
1st District	3 years	May	1962	May 1965	Ludwig L. Simon, M.D. Essex County
4th District	3 years	May	1962	May 1965	William E. Bray, M.D. Burlington County
Medical Services					
1st District	3 years	May	1962	May 1965	Francis J. Benz, M.D. Morris County
4th District	3 years	May	1962	May 1965	Frederick W. Durham, M.D. Camden County
Public Health					
1st District	3 years	May	1962	May 1965	Estelle T. Milliser, M.D. Union County
4th District	3 years	May	1962	May 1965	Anthony P. DeSpirito, M.D. Monmouth County
Public Relations					
1st District	3 years	May	1962	May 1965	S. William Kalb, M.D. Essex County
6th Member	3 years	May	1962	May 1965	Howard C. Pieper, M.D. Monmouth County

Standing Committees:

Annual Meeting	3 years	May	1962	May 1965	George J. Kohut, M.D. Middlesex County
Finance and Budget	3 years	May	1962	May 1965	Charles A. Landshof, M.D. Hudson County
Medical Defense and Insurance	3 years	May	1962	May 1965	William L. Palazzo, M.D. Bergen County
Medical Education	3 years	May	1962	May 1965	Frank S. Forte, M.D. Essex County
Publication	3 years	May	1962	May 1965	James J. Fitzpatrick, M.D. Mercer County
Woman's Auxiliary Advisory	3 years	May	1962	May 1965	Ralph K. Bush, M.D. Camden County

**Nominated from the Floor.*

Upon motions duly made, seconded, and carried, all nominess were elected to the designated offices and for the terms indicated.



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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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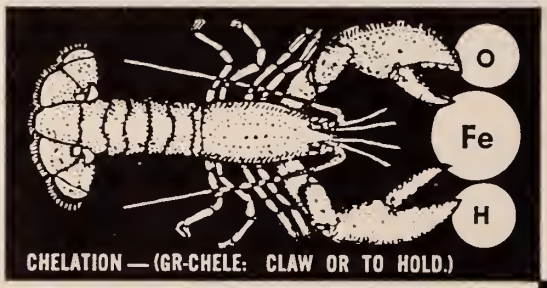
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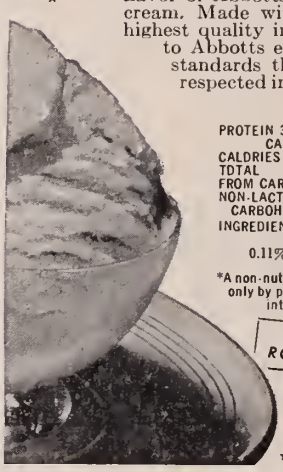
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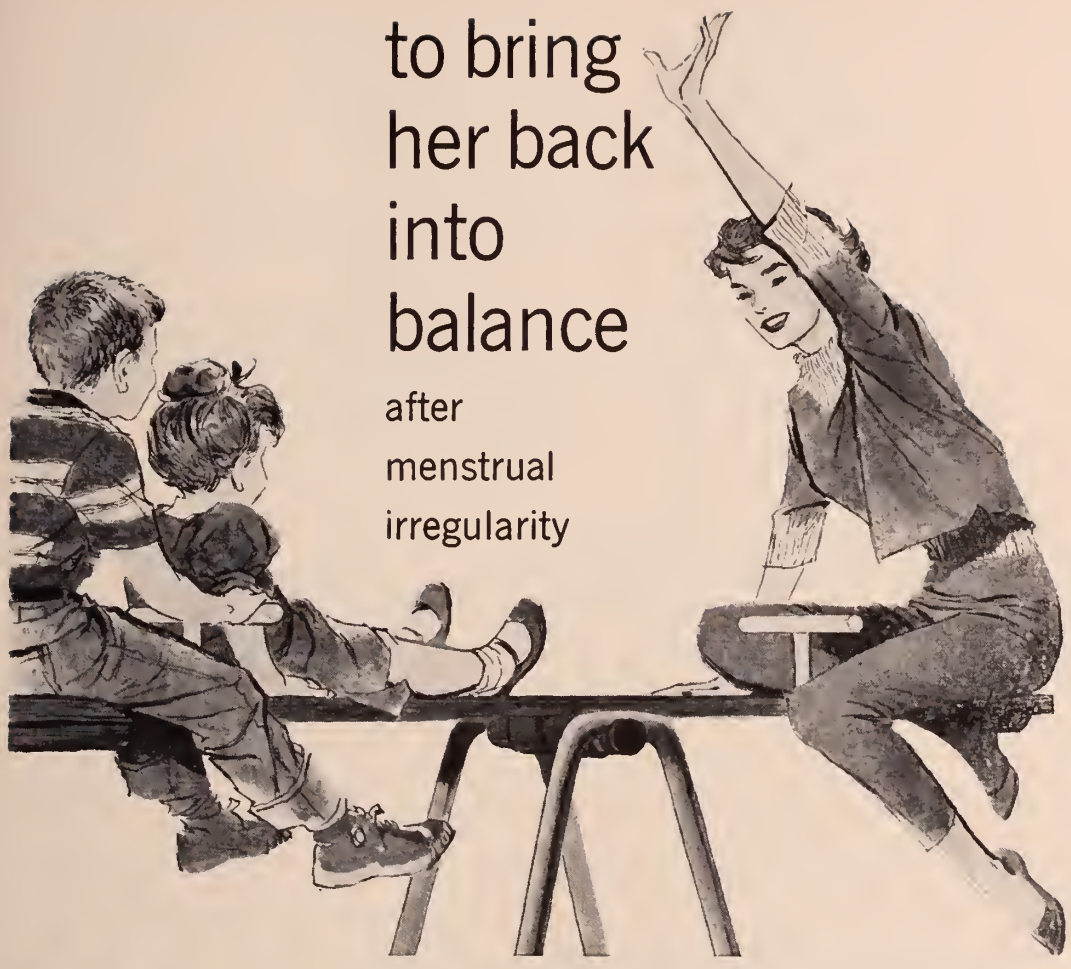
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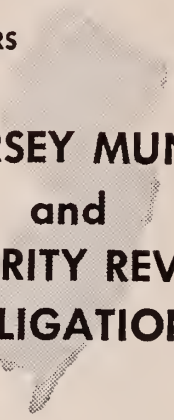
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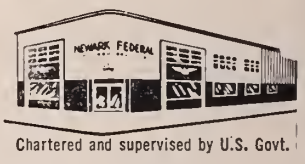
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References: (1) Minchew, B. H., & Cluff, L. E.: *J. Chron. Dis.* **13**:354, 1961. (2) Wallmark, G., & Finland, M.: *Am. J. M. Sc.* **242**:279, 1961. (3) Wallmark, G., & Finland, M.: *J.A.M.A.* **175**:886, 1961. (4) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 14. (5) Hodgman, J. E.: *Pediat. Clin. North America* **8**:1027, 1961. (6) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* **173**:475, 1960. (7) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* **105**:398, 1960. (8) Goodier, T. E. W., & Parry, W. R.: *Lancet* **1**:356, 1959.

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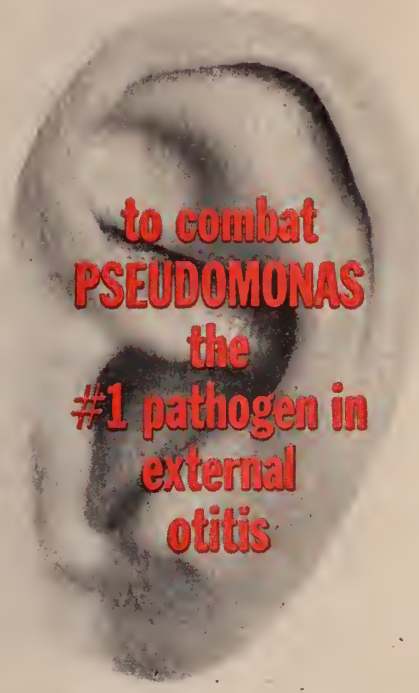
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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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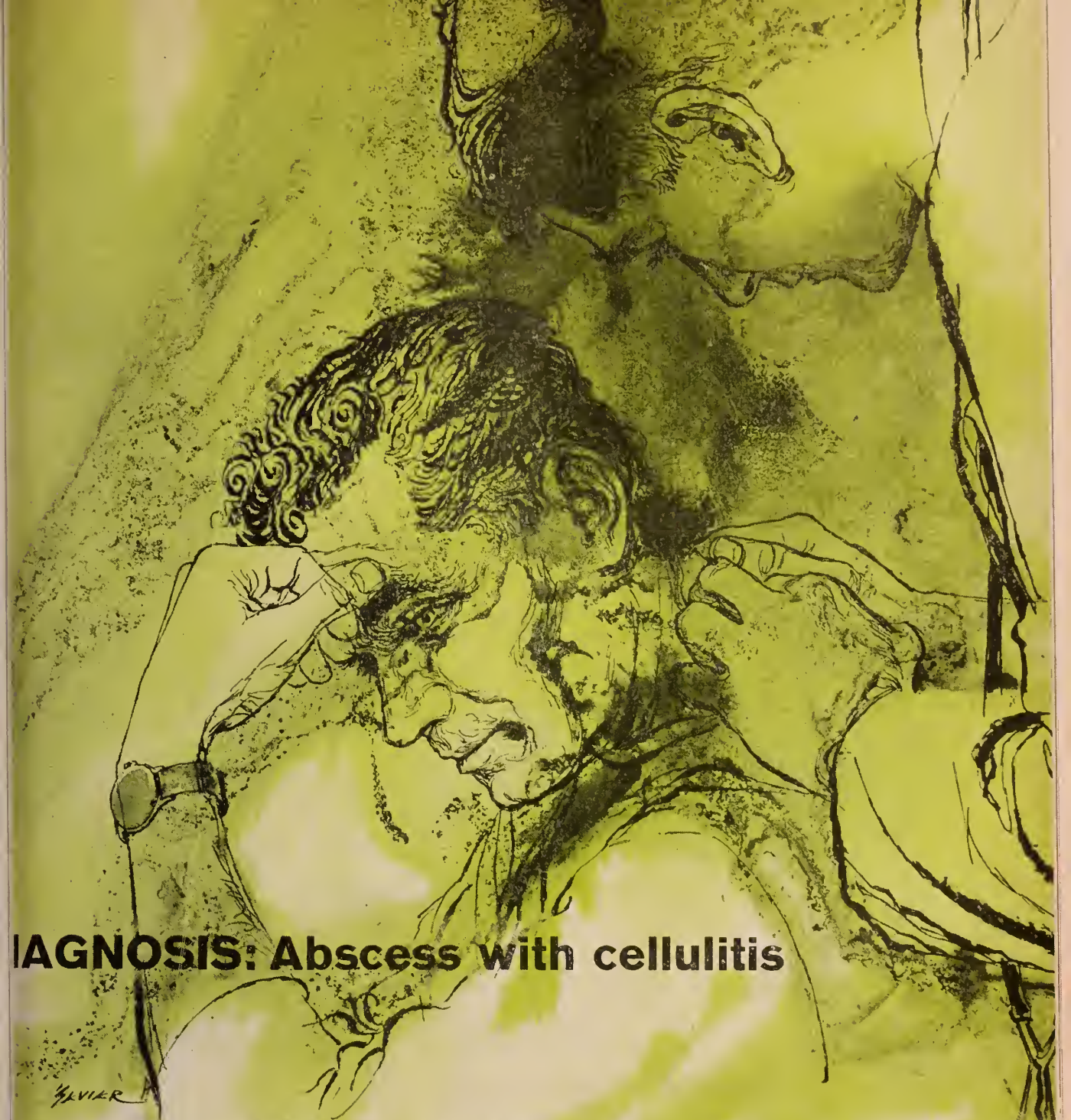
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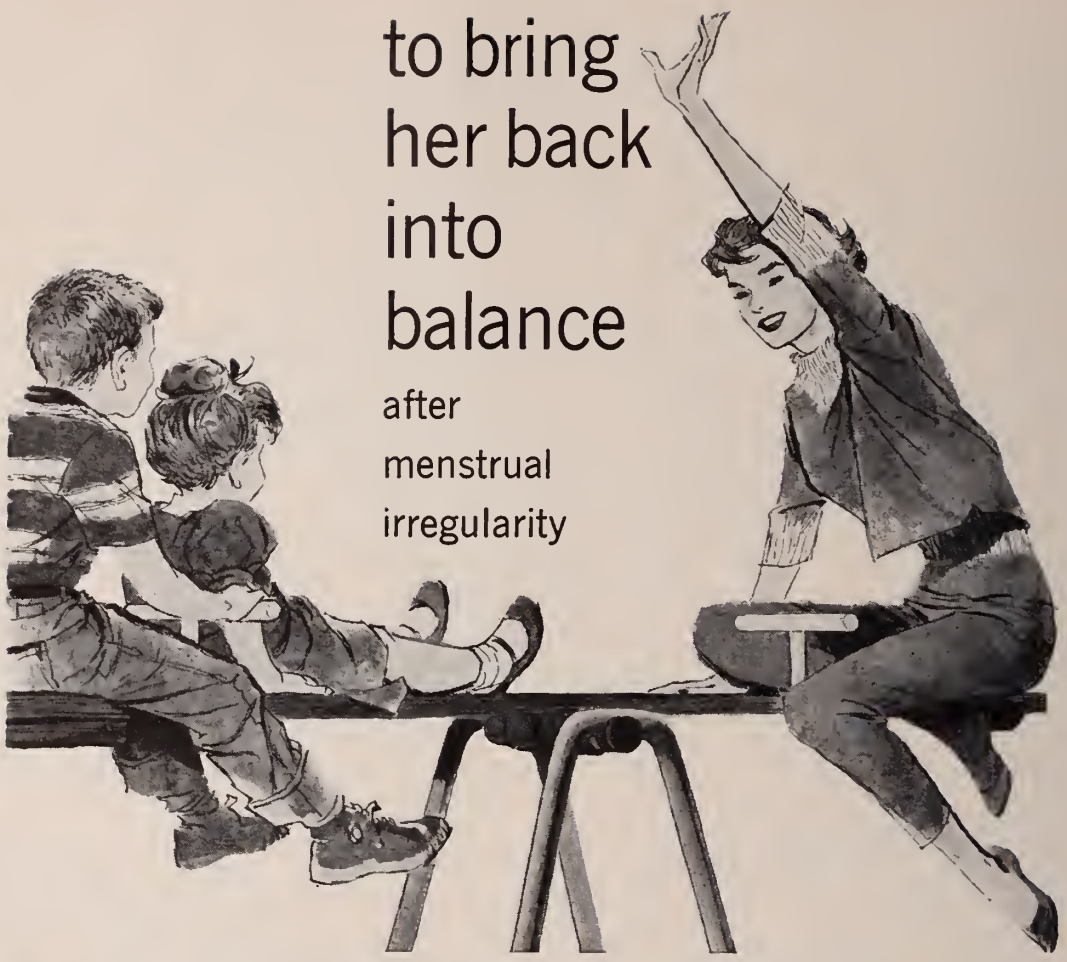
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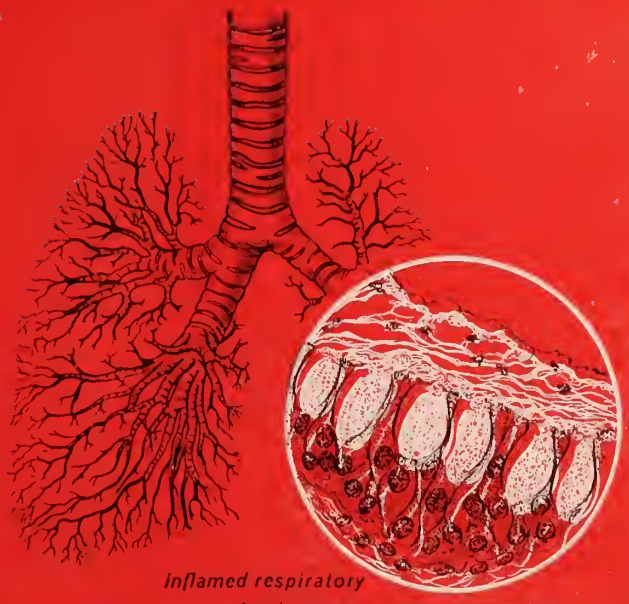
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1. Taub, S. J.: Clin. Med. 7:2575, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 3. Billow, B. W.; Cabodeville, A. M.; Stern, A.; Palm, A.; Robinson, M., and Paley, S.S.: Clinical Experiences with Oral Anti-inflammatory Enzyme for Intestinal Absorption. Southwestern Med. *41*:286, 1960.

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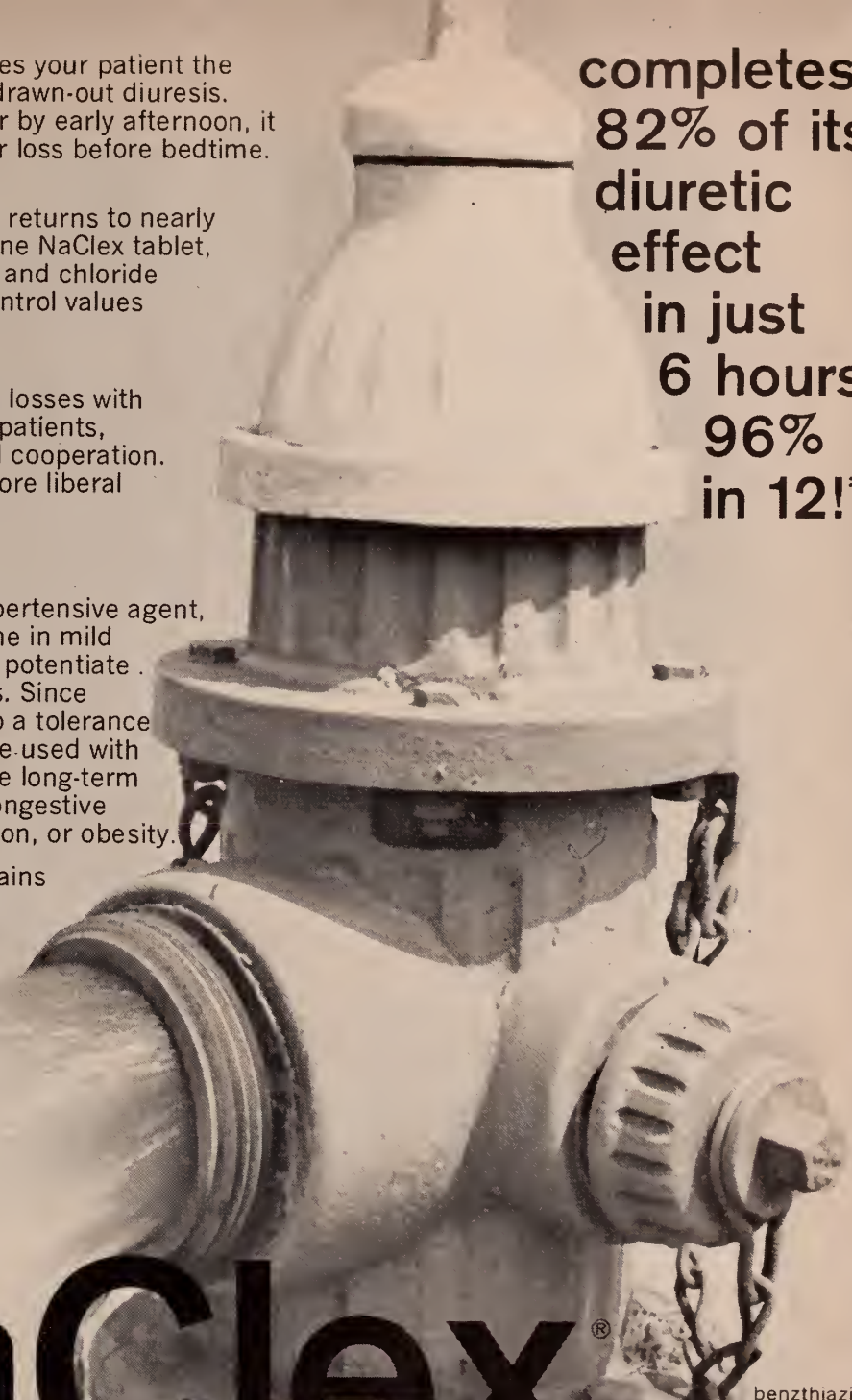
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*R. V. Ford: Cur. Ther. Research, 2:51, 1960.

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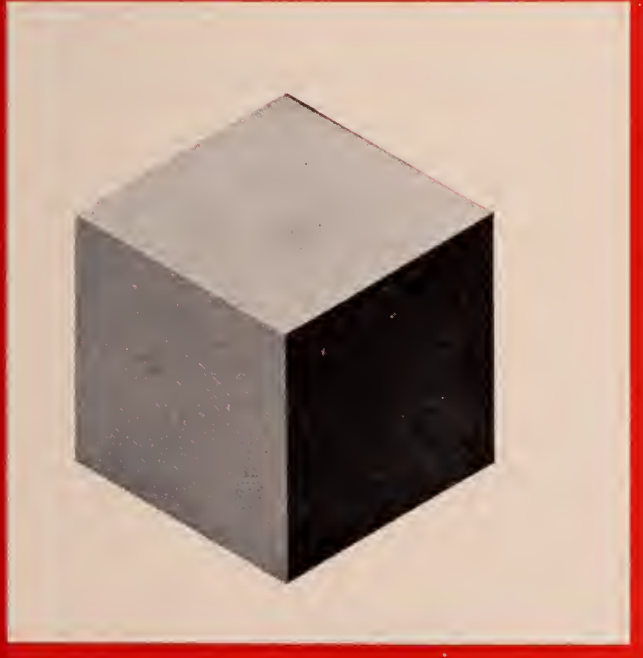
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—Gray, H. R., Wolf, R. L., and Doneff, R. H.: Evaluation of Flurandrenolone, a New Topical Corticosteroid, Arch. Dermat., *84*:18, 1961.

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Editorials • • •

The Fish in Man

One of the conspicuous differences between modern medical curricula and medical school studies prior to 1930 has been the emphasis on electrolytes, body fluids and ion exchanges. The importance of fluid and electrolyte balance emphasizes the fact that we all came out of the sea, and that there is still much of the fish in man. The menstrual cycle itself is reminiscent of the influence of the moon on tides. The salinity of our body fluids mimics the salinity of the ocean. And, in the words of one unidentified but sensitive author[1] "man is a collection of semi-permeable sacs." The whole body, indeed, may be visualized just that way. And much of human physiology may be thought of as movement of fluid and electrolytes across semi-permeable membranes.

Nature has provided an awesomely complex but awesomely efficient fluid and electrolyte balance. It does not tolerate persistent abuse, however. We are not, like the camel, able to reprocess waste urea[2] into new protein, or lose vast quantities of total body fluid without going into shock, nor are we constantly clothed in a camel's hair coat which valiantly assists in the maintenance of body temperature, thus reducing the role of evaporation.

In a sense, all life depends on differences in ion concentrations on opposite sides of our many semi-permeable membranes. Any such difference sets up an electrical potential, without which muscles and nerves would lose all excitability. Sodium and potassium ions move in and out and across and symbolize the movement that is of the stuff of life itself. Electrolytic rest, perfect ionic balance, and impenetrable inter-sac membranes would mean only the frozen stability of death.

All this has clinical meaning, too. Hypokalemia, for instance, is a common and serious[3]

1. The author of the article in the *Lilly* Physicians' Bulletin, 26:1 (February 1961).
2. Schmidt-Nielsen, Karl: *Scientific American*, 201-140 (February 1959).
3. Surawicz, Boris *et al.*: American Journal of the Medical Sciences, 233:603 (June 1957).

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metabolic disorder. Its intelligent management requires more than mechanical following of instructions found in a tabulation in a medical journal. The doctor has to know something of the complex physiology of electrolyte balance, too. Indeed, we must learn to think less in terms of classical disease entities (apoplexy, cholelithiasis, dysentery) and more in terms of hydration, ion exchange and electrolyte balance mechanisms.

It has been said that increasing knowledge of biochemical factors in disease has reduced the need for concern about emotional components. The two, however, are not incompatible. Emotions have a swift and measurable effect on electrolyte metabolism. Thus, Barnes and Schottstadt[4] have shown that the emotions of anger and apprehension increase sodium excretion; and that depression and quiet tension decrease it. A man in delicate cardiac balance may be hurt or helped by the physician's attitude; for if a patient has decreased cardiac reserve, an episode of decompensation may be precipitated by a discouraging attitude on the part of his medical attendant.

There are no dichotomies of "either-or" in medicine. Man's marine heritage is still apparent in his body physiology; but the emotional superstructure that has been added after eons of evolution is there, too.

4. Barnes, Ralph and Schottstadt, William: American Journal of Medicine, 29:217 (August 1960).

*Polysynonomy: The Drug Name Syndrome

"Polysynonomy" of drugs has been called a sin. Whatever it is, the habit of giving many names to the same compound is costly, confusing, time-consuming, and may constitute a health hazard.

Several groups are trying to eliminate the verbal epidemic of generic descriptions. At a recent meeting of the AMA-USP Nomenclature Committee and drug manufacturers, some experts suggested solutions.

The joint Nomenclature Committee already has a well worked-out procedure for selecting nonproprietary names—but many snags occur.

According to the AMA's Council on Drugs, names are usually proposed by the manufacturers. The Committee screens these for suitability and possible conflict with existing names, then checks them against the World Health Organization's principles for nonproprietary names. Names are also submitted to the Pharmaceutical Manufacturers Association for clearing and publication in *Trademark Bulletin*, and to WHO for world acceptance.

The Nomenclature Committee has plans for eliminating synonyms:

(1) Establishing a Nomenclature Review Board, staffed by the USP, a representative of the Council on Drugs and a spokesman for the manufacturer, to settle disputes over names.

(2) Making compulsory a system, already generally used by manufacturers, of giving drugs in the research stage *code names,* rather than nonproprietary ones, until an official name is selected by the Committee.

(3) Publishing nonproprietary names recently adopted by the Committee.

The biggest problem of all, according to Dr. Miller, is: "What shall we call the drug?" Experts cannot even agree on a name for the class of names under discussion. Some call it "generic," others "nonproprietary," and Federal agencies tend toward "common or usual."

Some manufacturers solve the problem by using a full chemical description—which can produce a name like α [(α methyl-3, 4-methylenedioxyphenethylamino) - methyl] - protocatechuyl alcohol hydrochloride.

Coining names from chemical abbreviations has also resulted in unwieldy titles.

*This editorial is adapted from "What's In a Name," which appeared in the October 1961 *Medical World News.*

The chemist on the Committee, asked "Why object to therapeutic implications in a name?" Ignoring both chemical composition and therapeutic indications of a drug, he warned, could result in a compound being called "Henry," for instance. If it turned out to have an oxygen radical, it might be given the nonproprietary name "O. Henry."

Dr. Miller suggested simple names, following the example of the FDA which has recommended that acetylsalicylic acid be labeled "aspirin." Dr. Windsor C. Cutting, on the other hand, urged that all drugs have names indicating their family. All sulfas, for example, should start with the prefix "sulfa," and barbiturates should end in "barbitol."

Walter C. Derenberg, professor of trademark law at New York University, advised: "The more informative the nonproprietary name, and the more nonsensical the tradename, the better—from a legal aspect."

A subcommittee will start writing a list of guiding procedures for standardizing drug names, which the Committee hopes will be accepted. If the subcommittee fails, a provision in the Kefauver bill would turn over the drug-naming job to the Department of HEW.

Medical Facilities in Housing Developments

Every summer camp, large factory, boarding school, and similar installation has a medical facility with professional staff on duty or on call. Throughout the country we are now building huge housing developments—sometimes row on row of one-family houses; sometimes high rise apartments; sometimes colonies of compact apartment houses. Here is an extraordinary opportunity for a new type of community medical care. Let us have built into each such development an infirmary where long-term care can be provided for those with chronic illness and convalescent care made available to those recovering from accidents, surgery or acute illness. The primary function of this installation would, of course, be the welfare of the patient. As Ross* puts it in presenting this proposal to Mayor Carlin:

"Let us have a place where sick people may be nursed in proximity to their loved ones, their family physicians and their clergymen. No apartment house should be built in this age without a space designed as an infirmary, including in its plans, a place to park the family physician's car The cost of operating a modern hospital does not allow for long-term nursing, nor does it provide an instrument for the tender care of those who must be helped to die with love, comfort, dignity and the provision for spiritual needs. The needs of terminal and convalescent care are the sand in the machinery of the modern hospital."

While this imaginative suggestion will take careful blueprinting, it is a feasible idea. The mind of man, capable of solving the very secrets of the atom, is surely capable of designing facilities like these. One incidental benefit of such a program is that it will offer a workshop for the general practitioner. Big city hospitals today tend to give the cold shoulder to the GP. But in housing development medical centers, the GP should be the central figure, not the peripheral one that he is in the modern medical center. This plan would also be a happy corrective to the over-centralization which is developing in modern medicine. Here is a proposal to bring the patient back into the community instead of letting him be centrifuged into a distant nursing home or a multi-storied medical center.

This interesting proposal merits medical leadership and initiative.

*Ross, Ira S., M.D., in an open letter to the Mayor of Newark. Dr. Ross is Chairman of this Society's Section on Psychiatry and Neurology.

LAURENCE A. DONAHUE, M.D.
Red Bank
GEORGE G. BRENNAN, M.D.
Sayreville

Lyophilized Urea in Traverts Solution® for the Treatment of Lead Encephalopathy*

Lyophilized urea has proved itself as a useful intracranial chemical decompressant, as Dr. Donahue and Dr. Brennan here show.

DESPITE manufacturers' efforts to eliminate lead from products which ultimately come into the hands of children, physicians (especially pediatricians) are still confronted with lead poisoning and its sequelae, acute or chronic. Children's toys and furniture generally are covered with lead-free paints; but other objects may not be, and this is especially true in the older and poorer sections of a community. Lead encephalopathy is one of the most dreaded complications of lead poisoning. Its mortality is high. Swift treatment is needed to offset the irreversible cerebral damage that may ensue.

To the pediatrician is delegated the task of treating the disease itself. He works with the neurosurgeon to cope with the emergent problem of controlling the convulsive seizures and lessening the cerebral edema. The former may, with occasional difficulties, be adequately accomplished by means of appropriate anticonvulsive medication. Cerebral edema, on the the other hand, has been an enigma to the neurosurgeon from the time of the first intracranial operation. In severe lead encephalopathy, the brain is diffusely swollen and edematous to a marked degree. This leads to the possibility of incisural or cerebellar herniation, and may result in permanent neurologic damage, or mental retardation; usually it is fatal. The neurosurgeon faced with this dilemma has no recourse but surgical intervention for decompressive purposes. We agree with McLaurin and Nichols [1] that an extensive cranial decompression (as advocated by Ingraham and Matson [2]) is the operative treatment of choice for increased intracranial pressure secondary to lead encephalopathy. Other and more physiologic methods have also reduced increased intracranial pressure. Constant ventricular drainage and carefully repeated lumbar punctures have been a useful adjunct.[3] These may be supplemented by the administration of the various hypertonic solutions given intravenously, orally, or, as enemas in an effort to promote cerebral dehydration.[4]

*From the Departments of Neurological Surgery and of Pediatrics, St. Vincent's Hospital of the City of New York.

1. McLaurin, R. L. and Nichols, J. B.: Pediatrics, 20:653 (October 1957).
2. Ingraham, F. D. and Matson, D. D.: *Neurosurgery of Infancy and Childhood*. Springfield, Illinois, Charles C Thomas (1954), Page 421.
3. Fay, T.: Annals of Surgery, 101:76 (1935).
4. Rowbotham, G. F.: *Acute Injuries of the Head*. Baltimore, 1954, Williams and Wilkins.

The disease itself is treated during this time by efforts to promote excretion of lead in the urine.

The hypertonic solutions alone or in combination have, at times, been effective in lead encephalopathy; but each has been found to possess some undesirable side effect which limits its use.[5] On the whole, the treatment of lead encephalopathy is unsatisfactory. However, we now have at our disposal a "new use of an old agent, urea,"[6] which has been found clinically effective and safe for the reduction of intracranial pressure.

Here is a case history where the results of lyophilized urea were dramatic and lifesaving:

A six-year old boy was admitted to the hospital on May 26, 1960 complaining of severe frontal and suboccipital headaches associated with anorexia, nausea and vomiting of four days' duration. There had been progressive lethargy for two days. There was no history of increased temperature, abdominal discomfort, bowel changes, recent injections or inoculations or the ingestion of toxic material. Past history and family history were noncontributory.

He was a well developed, fairly well nourished, extremely pale and lethargic child in acute distress. Temperature was 98.6; pulse, 88 per minute; blood pressure, 100/70. Despite the marked lethargy, he was able to respond sluggishly to verbal examination. The remainder of the general physical examination was normal. Neurologic examination was also normal except for blurring of the disc margins bilaterally and mild nuchal rigidity.

On admission, hemoglobin was 7.1 Grams and 45 per cent; hematocrit, 27 per cent; WBC's, 11,700 with 85 per cent neutrophils; 13 per cent lymphocytes, 2 per cent monocytes. Red cells showed three plus achromia, two plus anisocytosis, one plus basophilic stippling, one plus polychromotophilia, and one plus target cells. Blood lead level was 280 micrograms. The 24 hour urine specimen (780 cubic centimeters volume) revealed lead levels of 770 micrograms and the co-porphyrins were 78 micrograms.

The chest and skull films were normal. A flat plate of the abdomen revealed metallic deposits in the colon consistent with lead. X-rays of the lower extremities showed a slightly increased density of the metaphyseal line with some evidence of a second metaphyseal line of slightly increased density at the distal tibial metaphysis and distal femur. The electroencephalogram was normal.

Hospital course: The diagnosis of lead poisoning and early lead encephalopathy was made and treatment begun 16 hours after admission with 0.5 Grams of calcium versenate in 1000 cubic centimeters five per cent glucose and water. This was administered twice a day for seven days. Enemas were given to effect colonic lavage. Prophylactic antibiotics were administered and diphenylhydantoin, ¾ grain, three times a day was started, although there had been no convulsive episodes. Eighteen hours after admission, the child became markedly comatose and responded only slightly to painful stimuli. Respirations were of the Biot type, with 30 to 60 second periods of apnea. There was evidence of early extensor rigidity with pyramidal tract signs. A cut down was done and 100 cubic centimeters of 30 per cent lyophilized urea† was given at the rate of 30 drops per minute. There was noted almost immediately a definite improvement in respirations; and within a short time, breathing was normal. After two hours, the child was completely alert, sitting up in bed and talking. There was no neurologic deficit other than blurred optic nerve heads. In an effort to reinforce the decompressive effect of the urea lumbar puncture was done four hours after its completion. Initial cerebrospinal fluid pressure was 350 millimeters of water and the final pressure was 140 millimeters of water after 20 cubic centimeters of clear cerebrospinal fluid was removed. Ayala index was 8 units. Laboratory analysis of the spinal fluid revealed 3 white cells; protein 60 milligrams per cent; sugar 90 milligrams per cent; and chlorides 121 milligrams per cent.

During this time and the following two days, the fluid intake was limited to less than a liter a day, plus a soft diet. Temperature ranged between 102 and 104. He was mentally improved and no longer complained of headaches or nausea. There was no vomiting and his appetite seemed much better. Eye grounds still showed indistinct disc margins, but there was no other neurologic deficit.

On the third day of hospitalization, the fluid intake was increased to 2500 cubic centimeters per day and temperature returned to normal. On the seventh day, he again complained of a headache and stiff neck. Kernig's sign was positive, and a mild paresis of the right lateral rectus was observed. Breathing had again become rapid and pulse rate increased to 120. Flat plate of the abdomen at this time was negative for lead. The 24-hour urine specimen (525 cubic centimeters volume) revealed lead levels of 855 micrograms and the co-porphyrins were 53 micrograms. The blood lead level was 180 micrograms. He grew progressively unresponsive and his breathing became irregular. Urea was inaccessible at this time and therefore a substitute diuretic was used and the fluid intake restricted. There was no improvement in his condition. The first course of versenate was completed on the eighth day, at which time the child was again semicomatose with pathologic long tract signs. Temperature was 100.4; pulse, 140; and blood pressure was 100/78. Nucal rigidity was marked and signs of early decerebration were evident. There were absent venous pulsations over the discs. A hundred cubic centimeters of 30 per cent lyophilized urea† was again started, and within two hours the patient was completely alert with

†In the form of Urevert®, Baxter.

5. Lindberg, H. A., Wald, M. H. and Barker, M. H.: Archives of Internal Medicine, 63:907 (1939).

6. Javid, M.: Surgical Clinics of North America; Philadelphia, 1958, Saunders.

no subjective complaints other than mild blurring of vision. At lumbar puncture, initial pressure was 300 millimeters of water; final pressure was 150 millimeters of water after 10 cubic centimeters of clear cerebrospinal fluid had been removed. Ayala index was five units. Laboratory analysis of the spinal fluid showed no cells; protein 48 milligrams per cent; sugar 92 milligrams per cent; and chlorides 114 milligrams per cent. Hemoglobin was 6 Grams and 38 per cent. He received a blood transfusion of 400 cubic centimeters of packed red blood cells. Hemoglobin following the transfusion was 11 Grams and 70 per cent. The blood lead level was 45 micrograms. The 24-hour urine lead level (525 cubic centimeters volume) was 195 micrograms and the co-porphyrins were 52 micrograms. The second course of calcium versenate was begun and the blood lead level decreased to 64 micrograms after four days of treatment. Erythrocytes showed slight achromia, slight poikilocytosis and one plus anisocytosis. Hemoglobin was 10.7 Grams and 67 per cent. The second treatment of versenate was concluded on June 15, 1960.

On June 22, 1960, the blood lead level had reached 93 micrograms and the third course of calcium versenate was begun. It was terminated on June 25, 1960. He was discharged on June 30, 1960 with a blood lead level of 0 and hemoglobin of 11.1 Grams and 70 per cent. He was perfectly alert and showed no physical or neurologic deficit other than a mild blurring of both disc margins. His only complaint was a slight clouding of vision which did not seem to the examiner to be disabling.

It is not the purpose of this paper to emphasize the treatment of lead poisoning but rather to show the dramatic effect that lyophilized urea has on increased intracranial pressure as a result of lead encephalopathy. Lyophilized urea has been used on numerous patients in St. Vincent's Hospital prior to and during intracranial procedures to facilitate the operation. The effect has been amazing and the surgeon's work made much less difficult by the greatly dehydrated brain.

Urea is the principal excretion product of protein metabolism. When administered to normal individuals it is promptly eliminated because the storage capacity of the body for nitrogen is limited. It is a non-metabolic, non-electrolyte diuretic, 30 Grams of which are excreted daily in the urine on an average diet. It is excreted by the kidney only through glomerular filtration with less than 50 per cent reaching the tubules for re-absorption, the rest being unabsorbed, making possible the loss of large volumes of water by the osmotic effect of the unabsorbed part.

Since lyophilized urea causes marked diuresis, an in-dwelling catheter should be inserted and the total volume of urine excreted recorded. In this case, accurate urinary output records were not obtained; but they have been recorded in other instances and were found to be remarkably high.

Lyophilized urea administered intravenously is given in a dose of one Gram to 1.5 Grams per kilogram of body weight, as a 30 per cent solution, prepared by adding 210 cubic centimeters of sterile 10 per cent invert sugar in water (Travert®) to the 90 Grams of lyophilized urea. It should be administered at the rate of about 60 drops per minute. Its maximum effect should occur in about one hour and should persist for 3 to 10 hours. No other solution should be given simultaneously, and following its use, fluids should be restricted until cerebral edema appears to be under control. Javid[6] reached certain conclusions regarding the dosage and frequency of administration: (a) "The higher the initial cerebrospinal fluid pressure, the greater the pressure drop obtained. (b) The hypotensive effect on the spinal fluid is more pronounced and better sustained with larger doses. (c) It is possible to lower cerebrospinal fluid pressures below normal levels in doses which are well tolerated, although this is not usually warranted. (d) Lyophilized urea can be administered at frequent intervals over protracted periods without ill effects."

Unfortunately, lumbar punctures were done in this case only following the administration of lyophilized urea so that accurate pressures were not obtained prior to treatment. On both occasions the initial pressure was 300 millimeters of water or more, which is still above the normal levels. Before the administration of lyophilized urea there were signs of early cerebellar herniation as indicated by the suboccipital headache, nuchal rigidity, long tract signs, and progressive unresponsiveness. These signs and symptoms were not evident following treatment, which leads one to believe that the cerebrospinal fluid pressure must have been much higher before the lyophilized urea was given. Lumbar punctures were per-

formed from two to four hours after completion of the lyophilized urea, at which time the patient was nearly normal in the mental sphere. We may then be justified in concluding that the decompressive effect was the result of lyophilized urea alone. This decompressive effect is apparently distinct from its known diuretic action. It reduces the cerebrospinal fluid pressure by direct osmotic influence on the blood-brain barrier.[7]

No untoward effects have beeb noted in this hospital following the administration of lyophilized urea in over 50 patients other than a mild phlebitis at the point of needle injection. It has been used on numerous occasions by the former author while in the experimental stage and since this presented case without complication. The blood urea normally ranges from 20 to 35 milligrams per 100 cubic centimeters, and toxic levels may be reached. Lyophilized urea is, therefore, not recommended in patients with renal damage except as a lifesaving procedure.

SUMMARY AND CONCLUSIONS

A SIX-YEAR old child with acute lead encephalopathy due to chronic lead poisoning was successfully treated with calcium versenate and lyophilized urea. On two occasions the patient evidenced signs of increased intracranial hypertension. In both instances, lyophilized urea produced satisfactory clinical signs of decompression promptly and without untoward effect. Lyophilized urea would seem to be a potentially useful adjunct in the management of lead poisoning with associated acute lead encephalopathy.

7. Javid, M. and Anderson, J.: Journal of Laboratory and Clinical Medicine, 53:484 (March 1959).

87 East Front Street (Dr. Donahue)

Intravenous Technic Hazards

The following communication from our State Health Commissioner is published for the guidance of all readers.

A number of hospitals are using a technic of intravenous anesthesia that is subject to serious risk. An intravenous barbiturate, succinyl choline, or other muscle relaxants, are prepared in a large flask of saline solution. This flask is used to provide anesthesia by intravenous infusion to more than one patient.

The sodium chloride for injection described in the U. S. Pharmacopeia for multiple dose use is to be supplied in vials not exceeding 30 cubic centimeters volume and containing a bacteriostatic agent.

Normal saline is not prepared for multiple dose use. While the container is originally hermetically sealed, it cannot be resealed with assurance that sterility has been maintained. The flasks do not contain a bacteriostatic agent, as required by the U. S. Pharmacopeia for multiple dose containers.

The 1000 cubic centimeters, 500, 250 and 100 cubic centimeter flasks of saline are much larger than U. S. Pharmacopeia specifications, do not contain a bacteriostatic agent and once opened their sterility cannot be assured and for these reasons their contents *should not be used on multiple patients.* The intravenous tubing is changed between patients. The risks of breaks in this technic and human error are too great to accept this as a reliable safeguard.

The dangers inherent in using large flasks of intravenous saline containing anesthetic agents on more than one patient are such that this should be abandoned immediately in the interest of the patient, the hospital, and the public health.

Ira S. Ross, M.D.
South Orange

Electroencephalography in Behavior Disorders of Childhood

Not all juvenile misconduct is sheer orneriness. Some of it is due to gross pathologic and physiologic alterations in the brain as an organ.

The chapter in the progress of medicine concerning electroencephalographic findings in behavior disorders of childhood has not yet been written. Much is known about the incidence of abnormal electroencephalographic findings in the general population. Studies have been made of the incidence of abnormal electroencephalographic findings in people subject to epileptic seizures. Surveys have been made to determine the percentage incidence of abnormal cerebral electrical activity in prisons and in epileptic colonies; and, in much the same way, among groups of children who have become problems because of their behavior. These are lumped together as "behavior problem children." Studies of such children have been reported showing a ratio of abnormality as high as 70 per cent.

The inference drawn from such figures is that children become problems in behavior largely because they have physically disordered brains. However, experience of the New Jersey Diagnostic Center at Menlo Park does not bear this out. From 1949 through 1958, I have read 2432 records of the in-patient population alone. These are children whose disorder of behavior was so severe that they were remanded by the courts or admitted at a private request for observation and study largely to determine their fitness for treatment in the community or the need to deal with them in reformatory settings. Of these children, 363 or 6.7 percent have had abnormal electroencephalograms. The Menlo Park statistics thus suggest that you have to have a *better* functioning brain than normal to become delinquent. The accepted incidence of abnormality in the general population is in the range of 10 per cent. This is, of course, a ridiculous play on words as we know practically nothing about the meaning of cerebral electrical abnormalities in so far as they relate to behavior.

When the New Jersey State Diagnostic Center opened in 1949 it was generally felt that electroencephalography would be useful in a small number of selected cases where the possibility of brain disorder might form the major basis for the behavior disturbances that made it necessary for the patient to be at the Center. Dr. Lewis H. Loeser and I shared this view. However, it was also considered possible that minor brain disturbances might be contributing factors to an individual's behavior difficulty. Clinical methods are not as yet sufficiently refined to spot minor brain disorders. From the start the E.E.G. was made a routine part of the study of every in-patient and has remained so ever since. Thus, we know that of 2432 patients between the ages of 5 and 17, there were 363 with definitely abnormal E.E.G.s. This is 6.7 per cent of the in-patient population.

†Published by Addison-Wesley.

But "What is normal?" Gibbs and Gibbs in the 1950 edition of their *Atlas of Electroencephalography*† state: "Experimentation with wave counts and with frequency analysis of the electroencephalogram indicate that no objective index can equal the accuracy of subjective evaluation of the electroencephalogram if the electroencephalographer has learned to make those significant discriminations which distinguish between epileptic and non-epileptic persons. Accuracy should not be sacrificed to objectivity; except for special purposes analysis should be carried out as an intellectual rather than an electro-mechanical function."

They feel that their classification can be used with 98 per cent accuracy after three months of study by an average person. In their analysis of one thousand normal people (omitting symptom-free people with focal abnormalities) definitively abnormal records which include their "paroxysmal," S2 and F2 categories are found in 2 per cent, whereas borderline findings are found in another 14 per cent, if their S1 and F1 categories are added. In general, a figure of 10 per cent of the symptom-free population is accepted as standard for findings of abnormal E.E.G.s in samples of so-called normal populations. Our figure of 6.7 per cent for the in-patient population of children with problems of behavior in all likelihood represents the effectiveness of screening definitively physically afflicted youngsters by the medical examinations conducted by various agencies prior to admission to Menlo Park.

Of the 363 abnormal E.E.G.s of the in-patient population the following gives an indication of the kind of abnormalities found.

	Number	Per Cent
1. Paroxysmal dysrhythmia	69	19.0
2. Generalized and paroxysmal	25	2.5
3. Generalized dysrhythmia	116	32.0
4. Frontal dysrhythmia	20	5.5
5. Occipital dysrhythmia	17	4.7
6. Latent dysrhythmia	36	9.9
7. Immature patterns	27	7.4
8. Localized abnormality	50	13.8
9. Evidence of increased pressure	1	——
10. Increased cortical irritability	2	——
	363	100.0

We do not yet have figures of the incidence of epilepsy among these 363 patients. However, a disconcerting number of them have no manifest ictal symptomatology. This leaves open to question the meaning of these abnormal E.E.G. findings for the specific case. Disturbance of brain function depends greatly upon the physiologic importance of the specific area affected. A large lesion in a relatively "silent" area may give little clinical manifestation. Minute bilateral lesions in the region of the ventromedial hypothalamic nuclei in cats and rats will change previously tame animals into wild, savage beasts with voracious appetites. These animals then tend to become obese and to develop gonadal atrophy. Ablation of the epileptogenic amygdaloid areas of the temporal lobes in rats, cats and monkeys will produce gentle, tame, fearless animals with the males in sexually hyperactive state. Temporal lobe lesions in man are notoriously capable of producing periodic aberrant behavior in clouded states of awareness. Minute hypothalamic disturbance can result in great alterations of body structure and deportment. Some brain areas by neuronal interconnection are capable of impressing their peculiar frequencies on widely distant brain areas. This is apparently true of the thalamic pulvinar with the alpha dominance.

THE temporal areas tend to impress five to seven per second activity on divergent areas. Somewhere in the midthalamic region arises the three per second spike and wave sequence of petit mal. Such localizing trade marks are not altogether certain and appear to be relatively few. We have made a little start in trying to play back the meaning of abnormal E.E.G.s with regard to problems in behavior. The primal mud is still virginal in this territory.

To get some perspective of the contribution in case evaluation that is made from the brain wave laboratory, 200 consecutive cases of completely studied and discharged former in-patients at the Diagnostic Center were reviewed. These ranged in age from eight to

sixteen years. They were *all* problems in disturbed or delinquent behavior. All were referred to the Diagnostic Center because they posed problems too great for the juvenile courts to handle with their usual advisory staffs.

Of these 200 cases, 152 had definitely *normal* brain wave records; twelve had borderline; and 36 had definitely *abnormal* electroencephalographic findings. The definitely abnormal and the borderline cases (48 out of 200 or 24 per cent) were thus more common in this early group of young people than they might have been expected to occur in a random sampling of general population. The early case load included more children with organic brain disturbance than the present average.

Brain wave disturbances are of diagnostic value in epileptic disorders. Of the 36 cases with abnormal E.E.G.s, 4 were known to be subject to epileptic fits. Of the 12 borderline cases, one was known to have epileptic fits. Of the 152 normal records in this series, not one of the patients had any epileptic seizures.

E.E.G. Findings		Epileptic Fits	Periodic Aberrant Behavior
Definitely abnormal	36	4	12 (three of these have epileptic fits)
Borderline	12	1	3 (one of these has fits)
Normal	152	0	1 (no fits)

It may be hard to tell hysterical behavior from psychomotor epilepsy. In three of the five cases subject to epileptic seizures the nature of the attacks were of psychomotor type and the E.E.G. made the differential diagnosis possible. One of the patients was subject to jacksonian seizures. In this form of epilepsy, the attack begins with convulsive movements of one part of the body and spreads to other parts before the convulsion becomes generalized. Such seizures usually are associated with a localized area of brain damage. In this case, the E.E.G. indicated where this area of damage was located in the brain of the patient. The fifth was a *petit mal* epilepsy. This is a form of epilepsy associated with momentary lapses of awareness during which the patient stares and may blink his eyes or make rhythmic movements with his hands. These seizures are frequently regarded as mannerisms, periods of day-dreaming or absent-mindedness. The E.E.G. makes the diagnosis of *petit mal* epilepsy with 90 per cent accuracy. In this particular disorder it is one of the most specific laboratory tests known to medicine.

For many years it has been felt that people subject to periodic episodes of aberrant behavior might be afflicted with brain disturbances manifesting a peculiar disruption of energy by unprovoked explosive behavior, similar to the disruptive discharge of brain energy that occurs in epileptic fits. The following table shows an interesting relationship between the brain wave findings and the incidence of periodic aberrant behavior.

As can be seen from the above chart, one out of three of the children with definitely abnormal E.E.G.s is subject to periods of aberrant behavior out of keeping with his usual personality and one out of four of the cases with borderline findings is subject to such periods, but only one out of 152 cases with definitely normal cerebral electrical activity is subject to such periods. In considering these figures, it must be remembered that all 200 of these subjects were at the Diagnostic Center because of behavior that was not tolerable to our conventional social structure. The periods of aberrant behavior alluded to in the table are disturbances which are *not* commensurate with the particular subject's usual personality. Further research is needed to clarify the relationship between the E.E.G. disturbances and these periodic aberrant behavior disorders.

It has long been known that children may be subject to peculiar behavior disorders upon recovery from some forms of encephalitis. These children may manifest abrupt swings

of behavior ranging from extreme display of affection to violent aggression and destruction. In recent years, disordered brain waves in the posterior regions of the brain have been found in post-encephalitic conditions. Some medications have been found to have beneficial effect upon the behavior of these post-encephalitic children. Here, too, more research is needed.

Behavioral disturbances are seen in children with unusually unstable sugar metabolism. Brain wave disturbances occur fairly consistently with abnormally low blood sugar concentrations. These can sometimes be recognized in the E.E.G. study. More often, however, the electroencephalographer and the clinical physician must work together to recognize these cases and prescribe appropriate medication and diet. Occasionally, diabetic children who are difficult to control with insulin are found to have brain wave abnormalities similar to those seen in epileptics. In these cases, anti-convulsant medication makes the diabetes easier to control with insulin and diet. One such case was recently diagnosed at the Diagnostic Center.

Normal brain wave findings vary greatly from month to month during the first year or two of life and from year to year thereafter up to about 14 or 16 years of age. It requires considerable experience to appreciate the range of normal variations in the brain wave patterns from year to year in children. Research was carried out at the Diagnostic Center in an attempt to standardize better the norms from year to year.

Psychologic tests have been devised and used in psychiatric clinics to determine the possible presence of organic brain disorder. These tests have not been completely satisfactory. It would be valuable for clinical purposes to have easily administered tests that would indicate the presence of structural or chemical brain disease. The E.E.G. laboratory at the Diagnostic Center has been used to help evaluate such tests and further studies along similar lines are in progress.

Thus, in the Brain Wave Laboratory at the New Jersey Diagnostic Center current knowledge is applied and found useful in the day-to-day case load of diagnostic problems related to the behavior of disturbed, disordered and physically ill children. Investigational work goes on concurrently with the day-to-day routine studies. The future holds promise for further contributions to the understanding of these behavior problems in children from the Brain Wave Laboratory.

179 Irvington Avenue

CNS Defects and Endemic Goiter

A recently discovered, isolated, and still Neolithic population in the interior highlands of New Guinea, has been studied in which all of the members suffer from congenital central nervous system damage. The damage ranges from subtle degress of mental subnormality to severe feeblemindedness often associated with deafness or deaf-mutism. In this region about one-quarter of the males and two-thirds of the females have goiter. In some hamlets the incidence reaches 100 per cent among the adult females. Many of these goiters are among the largest in world literature. The extreme isolation and the high incidence of this congenital goitrous cretinism of varying degrees of severity makes this region ideally suited for studies of the genetic and environmental factors which determine the defects. Similarly, they offer an unprecedented opportunity to investigate the etiology and pathogenesis of central nervous system defects associated with endemic goiter. The possibility that an unusual use of sweet potato leaves as a dietary staple in a region where the total nutritional balance is marginally adequate may play a role in the medical situation is under investigation.

D. C. Gajdusek, *Pediatrics*, 29:345 (March, 1962).

William A. Dwyer, Jr., M.D.

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Arteriography in Localizing the Amputation Level in Arteriosclerosis Obliterans*

Siting the amputation line is a major responsibility for the surgeon. Dr. Dwyer's experience indicates that arteriography can help.

The middle-aged diabetic and the elderly arteriosclerotic patient with gangrene of the foot often pose a problem in deciding the best level of amputation. This decision is particularly important in younger patients when transmetatarsal amputation is considered; and in those who might be rehabilitated when the choice lies between below knee (BK) and above knee (AK) amputation.

The usual modalities are palpation of the pulse, oscillometry, and skin temperature readings. With these, almost every doctor has had a certain proportion of cases which failed to heal. The addition of arteriography makes possible a much more accurate estimate of the available blood supply and thus provides the surgeon with a reliable guide to the healing propensity of that area.

MATERIALS AND METHODS

Patients who had evidence of ischemic changes of the leg or foot have been evaluated by arteriogram over the past year and a half. To date, thirteen such cases (sixteen limbs) have been treated. Pre-operative estimation has been checked with postoperative results. The amputated limbs have been dissected and, in many instances, x-rayed postoperatively by injection of barium into the vessels to evaluate possible collateral flow that might have been missed by a proximal blockade.

For an overall view, see the tabulation at the end of this article. Three representative cases are detailed below.

CASE ONE

A 53-year old woman was admitted to the surgical service with a three-week history of swelling and ulceration around the fourth right toe. She was a diabetic, well controlled on diet and five units of insulin daily. Other systems were within normal limits. Examination was normal except that she had cellulitis of the plantar surface of the foot with a draining ulceration at the base of the fourth right toe. Most of the foot was swollen. Dorsalis pedis pulse could not be made out. There was a popliteal pulse on the affected side. Stool culture showed E. Coli sensitive to tetracycline, streptomycin, erythromycin and chloromycetin. Urinalysis showed a trace of sugar.

She was placed on bedrest, antibiotics and wet soaks. The diabetes was controlled by diet and fractional doses of insulin, according to urine sugar reaction. Five days after admission, incision and drainage were done. Her course continued unchanged. X-ray evidence of osteomyelitis appeared in the distal metatarsal heads and in the bones of the involved toe. At the end of a month, another incision and drainage were carried out without significant change in the course.

At the end of two months, the surgical staff felt that a below-knee amputation was necessary as there was just not enough blood supply to the foot to promote healing. An arteriogram (see Figure 1) showed adequate vascularity. Transmeta-

*This work comes from the surgical service of St. Joseph's Hospital, Paterson (N.J.).



Figure 1. Femoral arteriogram showing extensive vascularity of foot.

tarsal amputation was done, leaving the flaps open. She was dressed daily with bacitracin ointment. At the end of two weeks, the infection appeared to have cleared completely and a secondary closure of the amputation flaps was carried out. There were no sequelae. The stump has remained well healed over the past year and a half.

CASE TWO

An 89-year old man was admitted with gangrenous changes of the first metatarso-phalangeal joint with some surrounding cellulitis. He had always been in good health. This was his first hospital admission for any complaint. He was, however, somewhat emphysematous. There was a hallux valgus deformity bilaterally with gangrenous changes of the skin overlying the one on the right. There was surrounding cellulitis and some edema of the leg. There was a popliteal pulse on the affected side.

Oscillometric studies gave this picture:

	AK	BK	Ankle
Left	14	8	1½
Right	?	4	¼

Electrocardiogram showed only a right bundle branch block. Urinalysis was normal.

There was considerable debate as to whether this patient would not fare better with a below-knee rather than above-knee amputation. An arteriogram showed a complete block (see Figure 2) of the popliteal artery just above the bifurcation. On this basis, an above-knee amputation was advised as the only one with a reasonable chance of healing (see Figure 2). Despite this, a local excision of the affected toe and metatarsal was carried out, as the patient refused to accept any other procedure. This failed to heal and a below-knee amputation was carried out, again without healing. An above-knee amputation was finally done and this healed without incident.

CASE THREE

A 56-year old diabetic was admitted with a four-week history of minor trauma to the right foot, followed by infection and subsequent gangrene of the third toe and a portion of the adjacent one. Past medical history was non-contributory, except for a history of diabetes mellitus controlled by diet and tolbutamide.†

Physical examination was normal except for the gangrenous changes noted above. A dorsalis pedis pulse was noted on the affected side, but no posterior tibial pulse.

Femoral arteriogram showed a much diminished posterior tibial artery. He had a good dorsal arterial arcade. He was considered a marginal candidate for transmetatarsal amputation; but, because of his relatively young age, it was elected anyway. This was done in two stages, leaving the flaps open at the first stage and closing them at the second stage two weeks later. The stump healed uneventfully and he has been without complications for the eight months since discharge.



Figure 2. Femoral arteriogram showing blockade at level of popliteal bifurcation.

†We used the Upjohn brand, trade named Orinase®.

Age & Sex	Diagnosis	Palpable Pulses	Arteriogram Results	Pre-Operative Evaluation	Result
53 F	Osteomyelitis of toes Diabetes mellitus	Popliteal	All three vessels open	Transmetatarsal	As predicted
79 F	Arteriosclerosis obliterans Diabetes mellitus	Femoral	Popliteal occlusion No lower branches	AK only	As predicted
56 M	Arteriosclerosis obliterans Diabetes mellitus	Femoral	(1) Femoral occlusion (2) Same	AK only AK, possibly BK	As predicted Transmetatarsal done and failed Subseq. AK
53 M	Arteriosclerosis obliterans Diabetes mellitus	None	Left common iliac obstruction Right femoral segmental occlusion	AK only By pass graft	As predicted Failed Subseq. AK Amp.
89 M	Arteriosclerosis obliterans	Femoral and popliteal	Occlusion at popliteal bifurcation	AK only	As predicted
57 M	Arteriosclerosis obliterans Diabetes mellitus	Femoral	High femoral	AK only	As predicted
65 M	Arteriosclerosis obliterans	Femoral	Left femoral occlusion with collateral flow inadequate Right femoral occlusion with good collateral	AK only Possible sympathectomy. No other surgery	As predicted As predicted
66 M	Arteriosclerosis obliterans	Femoral	Femoral occlusion with good collateral	No surgery necessary	As predicted
61 M	Arteriosclerosis obliterans	None	Left iliac occlusion with no collateral	AK only	As predicted
58 M	Arteriosclerosis obliterans	Femoral	Scant collateral flow below knee	AK only	As predicted
74 M	Diabetes arteriosclerosis obliterans	Femoral	Ant. tibial occluded but good collateral	Transmetatarsal amputation recommended	BK amputation
70 M	Diabetes arteriosclerosis obliterans	Femoral	Femoral occlusion with extensive collateral	AK only	As predicted
56 M	Diabetes arteriosclerosis obliterans	OP	Ant. tibial open; Post. Tibial narrowed	Transmetatarsal amputation	As predicted

‡This case from the Cardiovascular Service, Passaic (N.J.) General Hospital

DISCUSSION

THIRTEEN cases is too small a number to justify definitive conclusions. None will be drawn in this preliminary report. Our findings do suggest, however, that there is a good deal of promise in this type of investigation.

The three cases presented illustrate the general experience that if there is sufficient blood supply to the area, it will be demonstrated on the arteriogram; and that healing will take place only where there *is* a blood supply. Dissection of amputated limbs in seven of these cases has reinforced this. In no case was there any demonstrable circulation except that shown on arteriogram.

Visualization of the arterial circulation has been achieved by both translumbar aortogram and direct percutaneous femoral arteriograms. No complications were encountered in any of these patients referable to this method of study.

SUMMARY

A METHOD of evaluating limbs for level of amputation has been used in thirteen cases with good preliminary results. Of sixteen limbs evaluated, fourteen behaved as predicted. Of the two failures, one had to have a below-knee amputation instead of a transmetatarsal because of the development of a decubitis ulcer on the heel while awaiting surgery. These results are tabulated and three representative cases are presented together with their arteriograms. This promising line of investigation deserves further development.

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How to Keep Scientists in Hot Water

In its March 1962 issue of *Events*, the National Society for Medical Research* reports that the California Appellate Court has shown antivivisectionists and similar organizations how to keep harrassing scientists. The Court decided that The Humane Society of the United States (not to be confused with the legitimate American Humane Association) could have arranged public hearings on its charges against Loma Linda University if it had called its charges "accusations" instead of "complaints."

The HSUS complaints were filed with the California Department of Health. After investigation, the Department found the complaints without substantial basis and closed the case. The HSUS demanded a public hearing on its charges. When the Department refused, the HSUS asked a court to order a hearing. The California Attorney General contended that citizens may complain, but only government authorities can, after investigation, lodge the accusations that are the basis for a public hearing. The Attorney General argued that this process is necessary to prevent unfair persecution of innocent parties.

The Appellate Court rejected this argument —even while denying the HSUS plea for a hearing of its case against Loma Linda—and thus opened the way for future persecution of California scientists with no need to establish probable cause.

California officials now believe that all or most of the licensing statutes of the state will have to be revised by the legislature in order to prevent capricious misuse under the formula outlined by the Appellate Court.

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Erythroblastosis Fetalis Due to Maternal Sensitization to Hr Factor by Blood Transfusion*

Women who are Rh positive need antibody testing, too, as Dr. Goodman here shows.

In hemolytic disease of the newborn, the clinical laboratory is of unique value in arriving at an exact diagnosis and in the prescription of therapy. Everyone knows the need for antibody testing in Rh negative women during the antepartum period. It is not so well known that this is also needed for women who are Rh positive. In fact, these procedures are not now performed with any regularity on Rh positive females unless a suspicion of sensitization exists because of some problem with past pregnancies or a history of transfusion reactions. A delay in accurate diagnosis and adequate therapy is the rule rather than the exception in such cases.

Hemolytic disease of the newborn due to maternal sensitization to Hr blood factor is well recognized. Formal case reports, however, are infrequent and, in some instances, lack essential information. Following is an example of maternal sensitization to hr′ (c) in an Rh_0 (D) positive female which occurred by a previous blood transfusion, but remained undiscovered until the birth of the second child.

A 29 year old white woman was admitted to the East Orange General Hospital on June 3, 1961, in labor. She had had a uterine myomectomy in 1958 for a large posterior serosal fibroid and was transfused at that time with one unit of compatible Group A, Rh_0 (D) positive blood. There was no evidence of transfusion reaction. In 1959, at the time of her first pregnancy, a cesarean section was done. There were no complications during gestation, and she received no further transfusions during that delivery or subsequently. A female child was born in 1959, three weeks prematurely and showed slight transient jaundice on the second and third days of life. The infant was not transfused, and there were no sequelae or complications. No subsequent laboratory studies were done on the mother's blood at that time, and no data were present to indicate red cell sensitization in the infant.

In 1961, during the second pregnancy, routine laboratory work revealed that she was blood Group A, Rh_0 (D) positive. No additional Rh subtyping or antibody testing was done prior to this delivery. Cesarean section was performed on the day of her admission. The infant was a male in good physical condition. Birth weight was 7 pounds, 10 ounces. No jaundice or edema was noted, and no routine cord blood studies were made. The infant was circumcised at birth without complications. On the third hospital day he was found to be moderately jaundiced without hepatosplenomegaly. The temperature was 99, and he was active and alert. Stools were yellow and light green. No abnormal neurologic findings were noted. The infant was blood Group A, Rh_0 (D) positive. On the third day the hemoglobin was 17.6 Grams (116 per cent) and the serum bilirubin 27. A direct Coombs test on the infant's red cells and Hemantigen tests on the infant's and mother's sera were all strongly positive. Panocell antibody typing on the mother and the infant revealed hr′ (c) serum antibodies. By the saline-Coombs method, the maternal antibody titer against known hr′ (c) posi-

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tive red cells was 1 to 64. (Antibody titers with enzyme-treated cells were not performed, but would probably have been higher.) The Rh-Hr typing of the infant and mother revealed the genotype of the mother to be R^1 R^1 (CDe/CDe) and the infant R^1r (CDe/cde). It became obvious that the nature of the sensitization resided with the hr′ (c) factor, the mother being homozygous rh′ (C), and the infant heterozygous rh′ (C). Accordingly, it was advised that the infant be transfused with Group A, homozygous Rh positive blood, genotype R^1 R^1 (CDe/CDe), lacking the hr′ (c) factor. Saline, albumin and Coombs crossmatch tests with this blood were compatible in both the infant and the mother.

By the evening of the third day the infant's serum bilirubin was 35. The baby was then exchange-transfused with 520 milliliters of compatible blood, Group A, homozygous Rh positive (negative for hr′). Post-transfusion bilirubin was 31. On the following day the infant was again exchange-transfused with 450 milliliters of similar compatible blood through a femoral vein cut-down because of a dry and short umbilical cord stump. A catheter was left in the vein at that time anticipating the need for further transfusions. The second post-exchange serum bilirubin was 18. On the following morning the bilirubin was 21. The next day the serum bilirubin was 18.7 and the hemoglobin 14 Grams. Subsequent studies revealed progressive improvement in the level of serum bilirubin, and no additional transfusions were given. The infant continued to nurse for the next four days and was discharged from the hospital in good condition weighing 7 pounds.

Following discharge, the previous hospital records of the mother were reviewed. The blood donor of 1958 was recalled, and the first child was examined to determine, if possible, the exact source of the maternal hr′ (c) sensitization. The data, summarized below, indicate that the patient was initially sensitized by the one blood transfusion she received in 1958. The Rh genotype of the first child was identical to that of the mother, R^1 R^1 (CDe/CDe), and accordingly could not have been responsible or contributory to the problem. The Rh genotype of the husband was similar to that of the second affected child, R^1r (CDe/cde). Two weeks after the patient's discharge from the hospital and three weeks after delivery, the mother's serum was again tested for the presence of hr′ (c) antibodies, this time using the husband's red cells as antigen. With a saline-Coombs technic the titer of hr′ (c) antibodies in her serum was 1 to 128. The infant was also re-examined and showed no clinical evidence of anemia, jaundice or abnormal neurological manifestations. The possibility of underlying kernicterus, however, could not be entirely excluded. Subsequent children may be of either Rh genotype R^1 R^1 or R^1r. In the event of the latter, a problem of newborn sensitization would most probably recur. There is a likely possibility of a hemolytic transfusion reaction in the mother should she again receive blood of the genotype R^1r (CDe/cde) at some future time.

It is now twenty years since the first case of hemolytic disease of the newborn due to hr′ (c) sensitization was reported by Levine[1] in 1941. McCall, Rose and Taylor,[2] in 1944, presented the first recognized case in England. At that time, Weiner[3] offered the explanation that the Hr factor, hr′ or c, can only be responsible for hemolytic disease in offspring if the mother is Hr negative while the father and infant are Hr positive. It is recognized today that among Rh-Hr types, the Hr factor is second only to Rh_0 (D) in antigenicity, but at a considerably lower level of potency, and that erythroblastosis due to hr′ (c) sensitization is as serious a disease as that caused by Rh_0 (D) sensitization. In the literature, there are only a small number of cases of Hr sensitization although they must be more common than this information would suggest.

Clinically the incidence of hr′ sensitization by pregnancy alone appears to be small. In 1947, Potter[4] cited only one patient out of 7000 women tested for Rh-Hr factors at the Chicago Lying-In Hospital who during the second pregnancy became sensitized to hr′ (c). In 1953, Grundorfer[5] reported two instances

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BLOOD GROUPING AND Rh-Hr TYPING

Red Blood Cells	Group	(D) Rh_0	(C) rh′	(E) rh″	(c) hr′	(e) rh″	Probable Genotype	
Mother	A	+	+	—	—	+	R^1 R^1	(CDe/CDe)
Father	O	+	+	—	+	+	R^1 r	(CDe/cde)
1st Child	A	+	+	—	—	+	R^1 R^1	(CDe/CDe)
2nd Child	A	+	+	—	+	+	R^1 r	(CDe/cde)
1958 Donor	A	+	+	—	+	+	R^1 r	(CDe/cde)

of hr′ (c) sensitization with special reference to the etiologic significance of multiple blood transfusions in Rh positive women prior to gestation. These two cases occurred out of 12,226 pregnant women examined at the Newark Beth Israel Hospital between April 1947 and March 1952. In both instances the mothers were shown to be hr′ (c) negative and were previously transfused with hr′ (c) positive blood, and in both, the infants were treated successfully with blood transfusions lacking the hr′ factor. In 1956, Weiner and his associates [6] listed 13 cases of maternal hr′ (c) sensitization with hemolytic disease of the newborn in which five of the women had received previous transfusions and the remainder presumably sensitized by pregnancy alone. Other single cases have been reported [7] over the years in which sensitization occurred by both pregnancy and transfusion routes, and in several instances dual sensitization to hr′ (c) and rh″ (E) occurred.[8]

With present day methods of more acceptable and sensitive technics for antibody detection, greater numbers of cases will be brought to light. It is worthwhile to emphasize the hazardous procedure of transfusing Rh negative blood indiscriminately, especially to women of the childbearing age who are Rh positive without further Rh-Hr screening. In homozygous Rh positive individuals who lack the hr′ (c) factor, these recipients would be sensitized to the greatest degree because of the two gene dose of the Hr antigen which is present in the transfused blood.[9] Although routine pretransfusion testing for Hr blood factors may not appear practical, these procedures should be routine at least for all young female patients. The medical profession should be made aware of these dangers, and the use of Rh negative blood as a "universal safe donor" in either untyped or inadequately typed Rh positive cases is to be deplored. All available means should be employed for the prevention of sensitization to known blood factors which may lead to future hemolytic transfusion reactions or erythroblastosis in offspring.

The purpose of this publication is to offer additional evidence of hemolytic disease of the newborn from an Rh positive mother, the cause of which could only be detected by thorough study of the Rh-Hr blood factors, and in which the manner of sensitization was clearly ascribed to previous blood transfusion.

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7. Dunne, C. J.: *Blood*, 7:526 (1952).
8. Weiner, A. S. and Brancato, G. J.: *Anesthesiology*, 9:175 (1948).
9. Sussman, L. N.: Am. J. Clin. Path., 17:643 (1947).

300 Central Avenue

Appreciation is expressed to the Essex County Blood Bank, East Orange, N. J., for its cooperation in locating the 1958 donor and providing the fresh specimen of blood for testing.

Bathing Suit May be Shark Bait

The attention-getting swim suit is shark bait, but it is the color, not the cut, that attracts them. Marked contrast between the color of the swimmer's suit and skin is dangerous for ocean bathing, according to shark attack statistics reported by Dr. Leonard P. Schultz, curator of fishes at the Smithsonian Institution. Records of nearly 800 shark attacks occur between 8 a.m. and 7 p.m. in water warmer than 65 degrees F., within 150 feet of shore, and in the upper five feet of surface waters. Nearly 70 per cent of the attacks take place when the swimmer actually is swimming and nearly 20 per cent occur when the victim is spearfishing—*Science News Letter*, April 15, 1951.

George F. Stoll, M.D.
Belleville

Hydrothorax Associated with Ovarian Carcinoma, Simulating Meigs' Syndrome

Report of Two Cases

Hydrothorax in a female patient should alert the physician to the possibility of benign or malignant pelvic disease. If this is not thought of, it may be missed.

The term Meigs' syndrome was originally[1] reserved for cases which met the following four criteria: (1) A fibroma of the ovary, associated with (2) hydrothorax, and (3) ascites, and where (4) the hydrothorax and ascites disappeared when the fibroma was removed. In 1954, Meigs[2] broadened the first requirement and included thecomas, granulosa cell tumors and Brenner tumors.

Prior to the article by Meigs and Cass,[1] Cullingworth in 1879 and Demons in 1887 reported cases of fibroma of the ovary associated with hydrothorax. In 1892, Tart suggested laparotomies for all patients with hydrothorax associated with abdominal tumors. Demons reported three other cases prior to 1903.

Millet and Hettesheimer[3] in 1953 cautioned that the mainfestations of Meigs' syndrome often masqueraded as cardiac signs and symptoms. They stressed that Meigs' syndrome along with advanced congestive failure, cirrhosis of the liver and tuberculosis should be considered in the differential diagnosis of patients with hydrothorax.

In 1950 Mackenzie and Hecht[4] reported for the first time a case of carcinoma of the ovary with hydrothorax, where the diagnosis was made by cytologic examination of the chest fluid. Malignant cells were identified in the material obtained by thoracentesis.

In a comprehensive review of the literature in 1954, Meigs[2] reported 122 cases, either of Meigs' syndrome or simulating it. In the former group were 84 cases which met the four criteria above outlined. In the latter group were 14 reports of cases associated with malignant disease of the ovaries or uterus. Nine of these were malignant, papillary cystadenoma of the ovaries. Since this report Deacon[5] and Mohrohisky[6] have reported two similar cases.

The paucity of cases simulating Meigs' syndrome but due to papillary cystadenocarcinoma of the ovary is borne out by the report of Allen and Herting,[7] who in 1949, reviewed 1740 cases of proliferative ovarian tumors, including 265 of malignant type, seen over a period of 43 years. They did not mention hydrothorax as one of the four most common physical findings, nor cough or dyspnea as one of the seven usual symptoms.

1. Meigs, J. V. and Cass, J. W.: Amer. Jour. Obst. and Gynec., 33:249 (February, 1937).
2. Meigs, J. V.: Amer. Jour. Obst. and Gynec., 67:962 (May, 1954).
3. Millett, J. and Hettesheimer, C. A.: Bulletin of the Medical School of the Univ. of Maryland, 38:4 (October, 1953).
4. Mackenzie, L. L. and Hecht, E. L.: New York State Journal of Medicine, 50:465 (February 15, 1950).
5. Deacon, A. L.: British Medical Journal, 1:317 (February 6, 1954).
6. Mohrohisky, J. R.: *Radiology*, 70:4 (April, 1958).
7. Allen, M. and Herting, A. T.: Amer. Jour. Obst. and Gynec., 58:640 (October, 1949).

Following are reports of two additional cases, simulating Meigs' syndrome, due to bilateral papillary cystadenocarcinoma of the ovary. In both, the diagnosis of malignant disease of the ovary was suspected by the signs, symptoms and cytologic examination of the pleural fluid. One of these patients is still alive and clinically free of her disease 55 months after surgery and roentgen therapy of the pelvis.

CASE ONE

A 45-year old woman was referred for diagnostic cholecystogram. Her history was that of vague "indigestion" in the right upper quadrant. She complained of a cough. The cholecystogram was normal. Chest x-ray revealed evidence of fluid in the right pleural cavity. Physical examination confirmed these x-ray findings. The remainder of the examination was negative. Thoracentesis revealed 1200 cubic centimeters of slightly cloudy, amber-colored fluid. Specimens were examined for tubercle bacilli and the usual pathogens and for malignant cells. No acid-fast organisms were found. Bacterial cultures were sterile. Cytologic examination of the fluid, using Papanicolaou technic, was reported as Class IV (cells of abnormal features, probably malignant).

Ten days later, she was hospitalized. Bronchoscopic examination showed an ulceration on the posterior wall of the right main bronchus. Biopsy report was chronic inflammatory tissue. Bronchial aspirations were examined for acid-fast organisms and none were found. The aspirations were also examined by the Papanicolaou method. Class I cells were found (absence of abnormal or atypical cells). Two thoracenteses were performed; one reported as Class I, and the other Class III (cells with abnormal features but not sufficiently pathogenic). Roentgenogram of chest after aspiration of fluid revealed no pathologic changes in lungs, heart or mediastinum. Venous pressure was 6 millimeters. Circulation time, arm to tongue, was 12 seconds; arm to lung, 6.5 seconds. The remainder of the physical examination and routine blood counts and urines were negative.

Prior to her second admission, two months later, a pelvic examination revealed an enlargement of the right ovary. Gynecologic consultation confirmed this finding. Cytologic studies of smears from the cervix were reported as Class I. X-ray examination of the chest then revealed massive pleural effusion on the right side. At the operation, the following day, a pint of cloudy, amber-colored fluid was found. Bilateral ovarian masses, friable and cystic, were also found. The tissue was reported as papillary sero-anaplastic carcinoma of the ovaries, bilateral. Roentgen therapy to the pelvis, using 2 portals, was begun a week later. A total of 2400 roentgens to each of two portals on the right and left side of the lower abdomen was given in a period of 10 days. A few days later, the roentgenologist reported a "normal chest." The patient has been free of any evidence of disease of the pelvis or lungs until the time of this report, eight years after the operation. Recent chest x-ray was negative.

CASE TWO

A 50-year old woman had a chief complaint of "nervousness." She had a history of cough and wheezing of three weeks' duration. Two years earlier, she had had a gynecologic examination where a fibroid uterus was noted. Five months after that, re-examination by the same gynecologist revealed the fibroid to have "grown larger."

She had massive pleural effusion, right, and an enlargement of the right ovary. The patient was hospitalized on the same day. X-ray examination of the chest ratified the physical findings. Gynecologic consultation confirmed the pelvic findings. Cytologic examination of cervical smear was Class I. Thoracentesis yielded 1500 cubic centimeters of cloudy, amber fluid. Cytologic examination of the pleural fluid was Class V (cytology conclusion for malignancy). At surgery, a moderate amount of fluid was found in the peritoneal cavity. Both ovaries were enlarged and replaced by tumor. The peritoneal cavity was studded with apparent metastatic lesions. Pathologic report was: serous, papillary cystadenocarcinoma of ovary. Secondary adenocarcinoma to omentum. Further surgery was done and x-ray therapy was given. She died six weeks after the operation.

SUMMARY

Two cases of bilateral adenocarcinoma of the ovaries, associated with ascites and pleural effusion, have been presented. One of these patients is alive and well 55 months after surgery and roentgen therapy to pelvis.

Meigs' syndrome is confined to benign lesions of the ovary. Review of the literature, plus the two cases presented, suggests that the criteria be broadened to include malignant disease of the ovary.

The findings of hydrothorax should alert the physician to the possibility of ovarian disease, and stimulate him to continue to examine the patient for pathologic changes in the pelvis.

330 Washington Avenue

Jack R. Karel, M.D.
Hillside

Sidney Ketyer, M.D.
South Orange

Hospital Radiologic Decontamination Center

Dr. Karel is Chairman, Civil Defense Committee, Union County Medical Society; Medical Coordinator, Union County Civil Defense and Disaster Control; and Chairman, Special Committee on Disaster Medical Services of The Medical Society of New Jersey. Dr. Ketyer is Director of Radiology at St. Elizabeth Hospital in Elizabeth.

Seventeen years ago the world entered into the nuclear era and with it came problems of great magnitude. One of these problems has swiftly come to the fore and is of intimate importance to hospital and doctor. In 1959 the Atomic Energy Commission decided to develop greater public benefits* from industrial application of radioisotopes and high intensity radiation sources. Much information was then declassified for use by industry in production chemistry and technology. From this time on there was a great upsurge in the use of radioisotopes in various laboratories.

Union County, New Jersey, is a highly industrialized area. Radioactive isotopes are being used and it was possible that an accident could occur in an industry where they were being used and that workers could become contaminated with radioactive chemicals. Therefore, the Medical Division of the Union County Civil Defense and Disaster Control organization in cooperation with the Radiology Department of St. Elizabeth Hospital in Elizabeth, N. J. developed a Hospital Decontamination Center. We hoped that this action might encourage the establishment of other hospital decontamination centers which would be available in case there ever was a nuclear attack. Little did we realize that this was a pilot project, the first of its type in New Jersey and probably in the United States. We soon found this out, however, following the release of this information on September 22, 1961. In addition to being a decontamination center, St. Elizabeth Hospital will be one of the fallout monitor stations for Union County.

Certain factors must be weighed in developing a radiologic decontamination center. The approach to the hospital must be at a place other than through the regular emergency entrance used for other types of medical cases. The entrance must not be through the main lobby either. This is to prevent contamination of the hospital areas most widely used for regular services. Upon entering the hospital, the contaminated individual would be taken to a reception room where he would be disrobed. His body would be completely checked for radiation. Clothes would be placed in a covered metal can and then taken to a storage

*U. S. Atomic Energy Commission: Major Activities in the Atomic Energy Program, 10-11, January through December 1959.

room. The covered can mimimizes the hauling of the clothes and also provides some shielding from the "hot clothes." The floor of the reception room should be coated with a peelable paint so that if heavily contaminated, it can be readily removed. A floor drain should be installed to aid in decontamination, leaving the stripping of the paint as a last resort. Emergency surgical instruments, drugs, plasma and parenteral fluids should be available in this room for treatment of any injury.

From the reception area, the patient would be taken to a special shower room containing a bath tub and shower combination in a glass enclosure. A tub would be easier to decontaminate and confines the contamination within the tub. Injured patients unable to stand could be immersed. After this, the radioactive patient is taken to a specially located hospital room for observation and treatment.

Heating, air conditioning or ventilation ducts should be completely separate from those of the rest of the hospital to prevent the spread of air-borne radioactivity. The floors of all the rooms should be covered with a peelable paint.

Radiologic instruments essential for the Center are: CD-V-700 Geiger Counter, CD V-710 Survey Meter or CD V-715, CD V-740 Dosimeter and CD V-750 Dosimeter Charger.

The radiologic treatment team may consist of the following doctors: two radiologic safety officers from the Radiology Department; two internists; one hematologist and one general surgeon.

In view of the serious international situation and the buildup of our Civil Defense program, we feel that Radiologic Decontamination Centers should be established throughout the United States and we hope we never have to use them.

The authors thank Paul Leggett, Jr., Sanitary Engineer, Radiologic Health Division of the United States Public Health Service, for his excellent suggestions and cooperation.

115 North Avenue (Dr. Karel)

Rehabilitation in Cerebral Palsy

With rehabilitation, two out of every three children with cerebral palsy show improvement, according to *Patterns of Disease,* a Parke, Davis & Company publication for the medical profession (issue of August 1959).

In some instances, results are dramatic. A before-and-after study of 881 patients cited by *Patterns* showed their total earnings before rehabilitation to be $91,000. After rehabilitation, their total earnings soared to $1,480,000—16 times more than previously!

Influenza Down in 1961

According to data released by the National Disease and Therapeutic Index, 1961 may turn out to be an unusually mild influenza year. The Index estimated only 1.7 million patient visits for influenza during the first quarter of the current year. This represented just 20 per cent of the 8.5 million visits projected for the first three months of 1960, an epidemic year. Historically, the first quarter of the year has always accounted for a large proportion of total influenza patient visits for the year.

Murray Levin, M.D.

West Orange

Treatment of Smoke Poisoning

Is smoke poisoning a gastro-intestinal rather than a respiratory problem? So Dr. Levin suggests on the basis of his long experience in fire department medicine.

When an individual is "overcome with smoke," he is usually removed from the area of trouble and given inhalations of oxygen. This is standard practice the world over, but there is no evidence that it does any good.

Having attended hundreds of emergencies of this nature, I have concluded that the oxygen is of no value, except, perhaps, in cases where the carbon monoxide titre of the blood has climbed to dangerous levels. A firemen in a smoke-filled area, with the air filled with products of combustion, does not actually inhale much of this; he gulps and swallows, and much of the smoke enters the stomach.

The by-products of burning rubber, wood, and other materials are complex acids which are swallowed in the body's effort to avoid inhaling the fumes. Some of this material may be inhaled; but not much. Oxygen is of little value in the treatment of these products. They penetrate the stomach wall and are absorbed into the blood stream, producing nausea, vomiting, weakness, sweating, and collapse.

The sensible treatment of smoke poisoning is to neutralize the complex acid by-products of the burning materials, as they are swallowed, and enter the stomach. This is done by giving calcium carbonate and glycine. This tablet can be carried by firemen and rescue workers who have to deal with these situations.

I have used this method of treating smoke poisoning for many years with hundreds of firemen. I can vouch for its value and effectiveness. There are thousands of fire departments throughout the country who, on rescuing someone from smoke, immediately apply oxygen. The oxygen is almost completely wasted (except in those cases in which some smoke is inhaled). The ideal treatment is to administer calcium carbonate to neutralize the products that have been swallowed. This affords almost immediate relief.

Admittedly, this simple procedure is not a cure-all for the treatment of gases, fumes and solvents encountered by a fireman in his daily work. However, it does offer a practical solution for a problem encountered daily in general fire fighting such as the average house fire or cellar fire. Treatment of poisoning from fumes in chemical fires requires more specific antidotes. Even with chemical fires, much of the material is swallowed in the body's effort to avoid inhalation; and the administration of this simple medication will go a long way in correcting the ill effects.

96 Washington Street

Trustees' Meetings

April 8, 1962

The Board met at the Executive Offices on Sunday, April 8, 1962. The business transacted included the following:

—Approved the request of the College of American Pathologists to urge our members to participate in the national prothrombin survey.

—Heard a communication on poliomyelitis immunization released by Commissioner Kandle. A joint statement by our Society and the Department of Health concerning the Salk and oral vaccines had been released on October 17, 1961. This action was taken on the recommen- of the Special Committee on Child Health and the Council on Public Health.

Action: Approved the issuance of a second joint statement. Wording of the statement will be cleared with the chairmen of the Special Committee on Child Health and the Council on Public Health, and Dr. Jehl.

Subsequently, the following joint statement was cleared and issued:

> The campaign to reduce further and to eliminate polio must continue. In addition to the inactivated (Salk) vaccine, all three types of live (Sabin) oral vaccine are now available. The optimum usefulness of both vaccines will be empirically determined. One will not replace the other.
>
> Polio occurs chiefly among the unvaccinated. Probably the greatest current unmet need for vaccination against polio exists among young parents, teenagers, and those citizens who have either not responded to, or been aware of, the educational programs undertaken in their behalf. The need for a continuing program of protection for infants and pre-school children is self-evident. The effective protection of these groups should remain our primary concern.
>
> Individual physicians and health officers will decide which of the two vaccines to use on the basis of their own appraisal of the special factors of their own practice or the circumstances within their own health jurisdictions. Availability of the vaccines may be a determining factor in the choice of which to use. Unlike the "Salk" vaccine, the oral Sabin preparations are presently type specific. All three types must therefore be given at different times to insure effectiveness.
>
> The State does not now plan to purchase large quantities of vaccine, and policies for supplying vaccine remain the same as hitherto.
>
> The consistent use of the oral vaccine among infants would have the advantage of increasing "herd immunity." Its more prompt antibody response makes the oral vaccine the vaccine of choice in the face of a type specific outbreak.

WHAM CAMPAIGN

In a letter from Mr. Stetler of the AMA, it was urged that New Jersey participate in the WHAM Campaign through its Auxiliary to stimulate doctors' wives to join with other groups in having letters sent to congressmen. The letters WHAM stand for "Women Helping American Medicine."

The Board noted that in a communication from Dr. Blaisdell, Federal Legislative Keyman for New Jersey, he too urged activity in New Jersey in this campaign.

Mr. Nevin reported that the Auxiliary has been actively engaged in the Society's campaign against HR-4222 and similar legislation —opposing such legislation not only from the point of view of what it will do to medicine, but also from the point of view of what it will do to the freedom of the country. "Operation Coffee Cup" has been conducted at local level, and people have been asked to have 100 letters each sent to Washington.

Dr. Allman stated that he did not see any good reason why the AMA personnel assigned to the WHAM campaign were not invited to New Jersey to stimulate the women in this State. There will be no cost involved and much can be done.

Action: The Society will invite the AMA to send WHAM representatives to New Jersey to collaborate with this Society's Auxiliary.

ACKNOWLEDGEMENTS

A communication was received from Attorney General Sills expressing appreciation of the welcome extended to him and thanks for his interest in the phases of his work with which this Society is concerned.

From AMPAC we received a note of appreciation for the support of the Board. AMPAC will seek New Jersey members in accordance with the Board's directive.

BLUE CROSS RATES

The Board's attention was called to the public hearing on the proposed increase in Blue Cross subscription rates to be held on April 12. While the inquiry is directly concerned with Blue Cross, charges may be made or statements uttered—concerning either the part of the physician or the function of Medical-Surgical Plan—which should not go unchallenged. It was agreed that Dr. McCall be authorized to attend the April 12 hearing as an observer and, if need be, as the official spokesman for the Society.

Action: MSP will be requested to send an official representative to the hearing to deal with any claims or questions that would involve the operation of MSP.

LIBEL AND SLANDER COVERAGE

Recently, through the National Bureau of Casualty Underwriters, coverage has been extended to physicians insured under stock company policies to include protection for certain committee work arising in libel-slander claims. This has resulted in duplication of coverage under the endorsement issued by American Mutual to the Medical Society.

An endorsement to the policy was suggested. It would afford full protection where needed, and would only eliminate duplication of coverage which is available to physicians under other insurance which they may carry and which specifically names the coverage.

The committee unanimously agreed that the following endorsement be added to the policy:

It is agreed that, notwithstanding anything to the contrary contained in Endorsement No. 4, as amended by Endorsement No. 6, the insurance afforded under such endorsements to any individual member of The Medical Society of New Jersey, with respect to his membership on a committee of The Medical Society of New Jersey or a component medical society of The Medical Society of New Jersey, shall not apply if such individual has other similar insurance available to him.

Action: The last three words will be deleted and the endorsement, as amended, is approved.

LEGISLATION

The Council on Legislation met on March 28, 1962. The following items were referred to the Board of Trustees for consideration and action:

Blood Bank Commission: Representatives of The Medical Society of New Jersey met with representatives of the New Jersey Blood Bank Commission and the Department of Health. From this meeting emerged a final version of proposed legislation to deal with the licensure of blood banks in the procuring and processing of human blood or human plasma for therapeutic or prophylactic purposes and to supplement "An Act in relation to a program for the collection, storage, and distribution of human blood" (approved May 3, 1945).

The council unanimously approved the proposed legislation which the Commissioner of Health will now recommend be introduced as an administrative measure.

Action: The proposed legislation is approved.

School examination law—S-204 (Ridolfi, Deamer). The council considered a communication from the Special Consultant in School Health Education of the State Department of Education (Geoffrey Esty, M.D.) in which he suggested amendment to this legislation to require that family physicians submit reports of their examinations on forms drawn up and supplied by the New Jersey Department of Education. The council could see no justification for the proposed amendment, and received and noted the correspondence.

X-ray and medical technician law—S-201 (Ridolfi). Council considered a communication from the Society of New Jersey Chiropractors, in which was recorded opposition to S-201 because it excludes legal protection to x-ray technicians who supply ancillary services to chiropractors.

The Legislative Analyst pointed out that the concern of the chiropractors is unfounded, inasmuch as the relevant section of the Medical Practice Act which is being amended concerns itself only with the practice of medicine and surgery and not with chiropractic. If the chiropractors desire to achieve protection for x-ray technicians whom they employ in the practice of chiropractic, they should proceed to amend that section of the law relating to the practice of chiropractic exclusively.

The council agreed that if it became necessary further to clarify this distinction with the Society of New Jersey Chiropractors, a conference might be held at the Executive Offices.

to which chiropractor-representatives will be invited.

The council received and noted a copy of a communication from the State Board of Medical Examiners to Governor Hughes, recording the Board's approval of S-201 and urging his action in its behalf.

Privileged Communication—Connecticut has a statute giving communication privilege to psychiatrists. It does not apply to all physicians. It was the opinion of the Legislative Analyst that it would be desirable in New Jersey to have privileged communication between all physicians and patients, and not limit such privilege to psychiatrists. The council requested that the Analyst draft such a measure, for review and action by the council.

From the Council on Public Health—Requesting that legislation be amended to include *all waters* of the state in the prohibition of discharge of pollutant matter or materials (not just coastal or tidal). The Department of Health has already made recommendations to this end.

Conference with Physical Therapists—In response to a request by the New Jersey Chapter of the American Physical Therapy Association, a conference was held on March 21. As a result of this conference, the representatives of the physical therapy group indicated their acceptance of the Society's proposal to regulate the practice of physical therapy by means of the proposed amendment to the Medical Practice Act to effect registration by the Board of qualified physical therapists. Council's Legislative Analyst will prepare the necessary legislation and submit it to the Council on Legislation, so that having cleared the council it would be ready for submission to the physical therapists.

The representatives of the New Jersey Chapter of APTA indicated that A-383 was not introduced at their request but was pushed by the New Jersey Physical Therapy Society. They gave assurance that they would not in any way support the advance of this legislation.

In the course of the council's deliberations, Dr. Schaaf telephoned to report that Senator Bowkley felt it would not be possible to withstand passage of A-383 in the Senate unless a substitute measure were available to the Senate within 24 hours.

In consequence of this information, the council authorized the chairman to make available to Senator Bowkley immediately the rough draft of the proposed amendment to the Medical Practice Act to effect registration of physical therapists, embodying the points agreed upon at the March 21 meeting. The council agreed that in thus presenting this draft to Senator Bowkley, it was doing so without having first cleared it with the physical therapists. However, in view of the emergency it felt that—having been assured of the attitude of the New Jersey Chapter of APTA—it was necessary to grant Senator Bowkley's request to withstand possible passage of A-383.

The council also directed that a telegram be sent to the New Jersey Chapter of APTA, and that by special delivery a copy of the draft as submitted to Senator Bowkley be sent.

Action: The draft of the legislation was approved. The action of the council, in sending a copy of the draft to Senator Bowkley, is also approved.

Psychology Bill—This would provide for the the examination, certification, and regulation of psychologists by a State Board of Psychological Examiners. *Disapproval, with Active Opposition if moved . . .* because it invades the Medical Practice Act and assigns to unqualified lay-individuals functions which they are not licensed or qualified to fulfill by permitting them to practice psychotherapy.

It was agreed that the primary objection to the measure was its inclusion of "psychotherapy" as a responsibility of non-medical psychologists. Psychotherapy is the treatment of disease and it is the belief of The Medical Society of New Jersey that psychotherapy embraces the practice of medicine; and in the public interest should be restricted exclusively to physicians and surgeons so licensed by the State Board of Medical Examiners.

Most of those present agreed that if the word "psychotherapy" were deleted from the bill, there would be no reason for opposing it.

In the interest of cooperating with the Psychological Association, the council directed that this portion of the minutes be transmitted to them, in the hope that they might remove the objectionable feature of this bill.

Action: S-211 will be disapproved as written; but approved if satisfactorily amended.

State Legislation—The council recommended the positions indicated. All bills marked (*) are identical with measures of last year, whose official positions at that time were the same as now.

S-195 *Weber, Hillery*—To revise certain qualifications for persons to be admitted to examination for license to practice medicine and surgery. *Disapproval, with Active Opposition if moved* . . . because it would circumvent the lawful procedure for the licensing of a physician adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. Thus it is contrary to the public interest and unfair to all those physicians who are legitimately and properly licensed by the State of New Jersey through the functions of the Board of Medical Examiners.

*S-201 *Ridolfi*—To amend the Medical Practice Act to permit medical and x-ray technicians to perform certain technical ancillary services to licensed physicians. (Society sponsored) *Active Support*

*S-204 *Ridolfi, Deamer*—To authorize school medical inspectors to accept evidence of a satisfactorily performed examination by the family physician in lieu of the required school examination. (Society sponsored) *Active Support*

*A-102 *Brady, Kijewski*—To provide for state reimbursement to counties for the cost of the maintenance of county institutions for the medical treatment of alcoholics. *No Action*

A-103 *Brady*—To define "resident" of a boarding home for sheltered care and permit standards to be fixed by the State Board of Control of the Department of Institutions and Agencies, upon recommendation by the Hospital Licensing Board. *No Action*

A-174 *Brady, Kijewski*—To provide for the registering of dental laboratory operators and assistants by the State Board of Registration and Examination in dentistry. *Disapproval* . . . in support of the position of the New Jersey State Dental Society which contends that the bill is loosely drawn.

*A-393 *Brady*—To make the requirement that containers shall be marked with the date of pasteurization applicable to cream. *Disapproval* . . . in conformity with the opinion of the U. S. Department of Health, Education, and Welfare that "the disadvantages are more significant than any advantages that may now be claimed for the dating of pasteurized milk" and in support of the contention of the Department of Health that the bill is not warranted or necessary.

*A-398 *Hughes, Krueger, McGowan, Kordja*—To provide that data in possession of the State Department of Health, pertaining to the health of any named person, procured in connection with research studies, approved by the Public Health Council, for the purpose of reducing the morbidity or mortality from any cause or condition of health shall be kept in confidence by the Department except to persons participating in research study or in such impersonal form that the individual concerned cannot be identified. *Approval*

*A-402, 404, 405 *Werner*—To establish presumption by statute in certain illnesses of firemen and policemen. *Disapproval* . . . because they involve diagnosis by legislative enactment rather than by medical investigation.

*A-427 *Bressler, Werner, Kijewski, Biber, Sweeney*—To oblige the State Board of Medical Examiners to make available for free distribution copies of all examination questions. *Disapproval* . . . in support of the position of the State Board of Medical Examiners, because these questions are freely available in the reference files of the State Library and compilations of Board questions are purchasable. It would be discriminatory against the taxpayers to adopt special legislation to provide copies of these examinations at the general expense to accommodate those interested.

*A-481 *Werner, Kocnig, Barbour, Yost*—To permit suspension or revocation of medical license where the holder has been guilty of willful or gross malpractice or negligence endangering life. *Approval*

*A-493 *Werner, Hughes*—To reorganize the administration of public welfare functions within the Department of Institutions and Agencies. *No Action*

A-534 *Hughes*—To protect licensed physicians who, in good faith, render emergency first aid or care at the scene of the emergency from civil acts or omissions in rendering such care. "Good Samaritan Act." *Approval*

A draft of similar legislation was approved by the council on April 12, 1961, to cover *all* persons who rendered emergency care at the scene of an accident or emergency. This measure would relate only to those persons licensed under the Medical Practice Act.

*A-559 *Werner*—To require the use of humane methods in the slaughter of livestock. *No Action*

*ACR-45 *Lynch*—To memoralize Congress to enact legislation providing for payment of hospital services, skilled nursing home services, and home health services furnished to aged beneficiaries under the old-age, survivors and disability insurance programs. *Disapproval* . . . because it is economically unsound, politically unwise, and socially unjust to call upon the general citizens to provide and pay for services which individual citizens are capable of providing and paying for themselves. It is the contention of MSNJ that only needed services which individuals and their families cannot provide or pay for should be made available through tax-supported programs.

Action: The recommended positions on the bills reported were approved.

RESIDENTS

The council received and noted a communication from the State Board of Medical Examiners informing the Medical Society that an amendment to the Medical Practice Act will be re-introduced as an administrative measure "so that doctors of medicine serving as residents might continue for five years in that status before being required to obtain a license to practice medicine in New Jersey."

Action: This is approved.

MEMBERSHIP PROCESSING

The following procedural standards, to cope with membership problems, have been adopted by the Committee on Credentials, and were referred to the Board for consideration and action:

Associate Members: When a member is applying for full membership status, biographical information must again be requested from AMA by the secretaries of the component societies.

Completing Membership Applications: The two regular member-endorsers must be members of the component society to which the applicant is applying.

Membership Assessments: Associate and regular members who have been dropped for non-payment of the annual assessment cannot be reinstated until such indebtedness has been discharged; but such indebtedness shall apply only to one year of delinquency.

Reinstatement: On February 7, 1960, the committee issued a ruling that "former regular or associate members whose memberships have lapsed for any reason must submit applications for committee approval before they may again be accepted as members." Enforcement of this rule resulted in some confusion, because no time limit has been stipulated.

The committee approved the following formula for determining the eligibility for reinstatement of associate and regular members who have been dropped for nonpayment of dues:

> If a member is dropped on June first and his assessment is received before the end of the same calendar year, he is to be reinstated immediately; but if assessment is received *after* the end of the calendar year in which the member was dropped on June first, the rule will apply and an application must be submitted for committee action.

Transfers: An applicant by transfer, from a component society in this or any other state, who does *not* hold regular membership (including the right to vote and hold office in that component society) must serve a probationary period of one to two years as an associate member. At the discretion of the component society, a regular member so transferring may be elected to membership without serving a probationary period.

An associate member desiring transfer from one component society to another shall re-submit a membership application for committee action as in the case of original applicants. This stipulation does not apply to regular members so transferring.

Action: The recommendations of the committee are approved.

DOCTORS OF OSTEOPATHY

To clarify application for membership for candidates whose basic degree is a doctorate in osteopathy the following resolution was drawn by Legal Counsel at the request of the committee:

> That applicants for membership in a county medical society of New Jersey whose basic degree is a doctorate in osteopathy must be considered for the same, provided they have: (1) A D.O. degree from a school recognized by the Board of Medical Examiners of New Jersey; (2) A license to practice medicine and surgery in the State of New Jersey, and (3) An M.D. degree from a school recognized as presenting a degree acceptable to the State Board of Medical Examiners or to The Medical Society of New Jersey.
>
> All applications for membership henceforth will be forwarded to The Medical Society of New Jersey for consideration by its Credentials Committee prior to final action by the component society.

Action: The resolution is approved and the component societies will be so notified.

PUBLIC HEALTH

From its meeting on March 28, 1962, the following items were referred to the Board of Trustees for consideration and action:

Hospital Tumor Registries—Through the State Health Department, two expert record librarians are available to hospitals to assist in setting up records and teaching abstraction of patients' charts. The committee suggests that training of personnel for cancer registries in individual hospitals be encouraged and supervised by the State Department of Health.

Action: This suggestion is approved.

It is vitally important to have the full cooperation of the hospitals for the successful operation of a central registry. It was suggested that for hospitals having no tumor registries, members of the committee could talk to administrators and medical directors to explain the central registry.

In view of the increasing pressure from the American College of Surgeons and the Joint Commission on Accreditation to maintain tumor registries, county cancer committees should cooperate in working with hospitals not having cancer registries.

Action: The final phrase of the recommendation is amended to read "county cancer committees cooperate with the special committee in working *to establish cancer registries* with those hospitals not having cancer registries"; this amended recommendation is approved.

Central Tumor Registry—The special committee can get a consultant on cancer registries from the National Institute of Health. He would be proficient in the establishment and operation of a central registry. It is recommended that a consultant on cancer registries be requested from the National Institute of Health to advise the committee on establishment and operation of a central registry.

Action: This recommendation is approved.

Tuberculin Testing of Students—The Committee on Child Health investigated the campaign in progress to encourage the use of the Tine Test (Lederle) for tuberculin testing of high school students. The committee reviewed literature on tuberculin testing and reports from the Lederle Laboratories, the Department of Health of New York City, the New Jersey State Department of Health, and Sternneedle Gun Technical Bulletin by Pamay Padam Corporation. The committee suggests that the Tine and Sternneedle Tests may be used where mass tuberculin testing is indicated without competent agents for administering the intradermal (Mantoux) test.

Action: The recommendation is approved.

Migrant Workers—Also discussed were health problems of the children of migrant workers in New Jersey. Information received from the Coordinator, Maternal and Child Health Program, State Department of Health, indicated that the problems are presently being taken care of adequately at local level. It is urged that our component societies of counties where migrant workers are employed establish liaison with the Coordinator of the Maternal and Child Health Program of the State Department of Health to determine in what spheres the component societies, through their members, may aid in the health problems of children of the migrant workers.

Action: The recommendation is approved.

Chronically Ill and the Aging—It is essential in the development and carrying out of this program to have active committees on chronically ill and the aging in the counties and to establish close liaison with such committees. It is recommended that The Medical Society of New Jersey provide secretarial help for the Special Committee on the Chronically Ill and the Aging when needed to provide liaison between the State Medical Society and county committees.

Action: The recommendation is tabled.

Home Care Program—At a meeting of the Advisory Council on the Chronic Sick, a discussion on home nursing care, coordinated home care, and home care services took place. At present in some sections of the State, Blue Cross is covering some of these services. However, there are no definite criteria set up to say what should or should not be included in this program. It is recommended that the Medical Society take action to establish policies and principles for the guidance of the Home Care Program under medical supervision and that these policies and principles be drafted by the Special Committee on Chronically Ill and the Aging with the cooperation of Dr. Kandle and the State Department of Health.

Action: The recommendation is approved.

Speakers' Bureau—The committee suggests that the Medical Society recognize that we have lacked positive action and are defaulting by our silence as a profession. The committee recommends that a speakers' bureau be set up under the direction of the Special Committee on the Chronically Ill and the Aging to include public appearances before senior citizen groups, nursing home groups, and the like—these appearances to be oriented toward the medical care of the aged.

Action: The recommendation is approved.

Maternal and Infant Welfare—In some areas maternal deaths are not being reported because they occur in connection with patients who are re-admitted to hospitals for some con-

dition following delivery. The State Health Department should notify responsible agents in each hospital that all deaths following a recent pregnancy (up to six weeks) be reported as maternal deaths and special notation be made on the death certificate as to date of delivery; and that an item be published in THE JOURNAL and/or the *Membership News Letter* to bring this recommendation to the attention of all members.

Action: The recommendation is approved.

Eye Health Screening Program—The committee has developed "An Eye Health and Eye Screening Program for Schools." The Committee desires to have this program made available to the superintendent and school physician of every New Jersey school—public, parochial, and private . . . elementary and secondary. Dr. Esty, of the State Department of Education, gave his opinion that the Department of Education would not undertake to pay for the printing of the brochure, but he felt confident that the Department would arrange for its distribution. The council adopted a motion to approve the school screening program, and recommended that The Medical Society of New Jersey underwrite the expense of printing 5,000 copies of "An Eye Health and Eye Screening Program for Schools" in brochure form for distribution to the schools of New Jersey—the superintendent and school physician of public, parochial, and private schools . . . both elementary and secondary. The estimated cost is $900 to $1000.

Action: The recommendation is disapproved at this time because of insufficient funds in the budget.

Ophthalmologist and Optometrist—For the convenience of the Executive Offices in answering inquiries concerning the differences between ophthalmologists and optometrists, it was the recommendation of the special committee, approved by the council: "That 100 copies of the pamphlet "Care of the Eyes" published by the U.S. Department of Health, Education, and Welfare (cost $3.00) be obtained to be supplied when requests are received concerning the differences between ophthalmologists and optometrists.

Action: The recommendation is approved.

Eye Health Screening Program—The committee recommends:

(1) That the 1962 Eye Health Screening Program on a state-wide basis be held during the week of September 24, 1962.

(2) That the Governor be requested to proclaim the week of September 24th as "Eye Health Week," and that such requests be sent to the Governor at least six weeks prior to the date the proclamation is desired.

Action: The recommendation is approved.

Optometric Advertising—Optometrists are now using billboard signs as a means of advertising. The signs include the wording ". . . See your family optometrist every year for a *complete* examination—A *Public Service Message* from New Jersey Optometric Association."

The council adopted a motion expressing its opposition to this type of advertising, especially to the word "complete" and the signature of "a public service." The committee asks that the Board of Trustees concur in this action of the council and take whatever steps are necessary to counteract this type of advertising.

Action: The matter will be referred to the Conference Committee with Optometrists.

Veterinary Seminar—The council reviewed the program for the seminar to be held May 23 in Haddonfield—"Enteric Diseases Common to Man and Animal"; and "Parasitic Diseases Common to Man and Animal." The President of The Medical Society of New Jersey is listed as giving the welcoming address at the opening of the seminar, and Dr. Kandle as introducing the afternoon session.

The seminar will be co-sponsored by the State Department of Health, and co-sponsorship by The Medical Society of New Jersey has been requested by the New Jersey Veterinary Medical Association. The committee asks that The Medical Society of New Jersey serve as a co-sponsor of this seminar program.

Action: The recommendation is approved.

Dr. Buchanan reported that the President of the Society, or his representative, has been invited to give the opening address at the seminar, and that he had referred the invitation to Dr. Wegryn inasmuch as the seminar will be held during Dr. Wegryn's administration.

Intra-Hospital Infections—The State Department of Health has received an increasing number of letters and requests for training programs in regard to intra-hospital infections. New Jersey has few experts in this field, and

it would be most practicab'e to establish a joint committee of medical, hospital, and nursing department representatives.

It is suggested that the Trustees establish a council or group—in cooperation with the State Department of Health, Hospital Association, Nurses' Association, and other interested groups indicated by the Board of Trustees—to investigate the possibility of establishing training programs in regard to intrahospital infections.

Action: The recommendation is approved.

PUBLIC RELATIONS

From its meeting on March 25, 1962, the following were referred to the Board of Trustees:

Telephone Directory Listings—There are divergent practices among component societies concerning telephone directory listings for members. In some counties specialty listings are included, while in others such listing is regarded as a breach of ethics. It would be an accommodation to component societies if the State Society were to recommend a uniform procedure that could be utilized by all component societies. The council recommends that component societies be requested to permit the listing of specialties and office hours in ordinary lettering in the Yellow Pages of the local telephone directory; and that the use of boldface type for such listings be prohibited.

Action: These two recommendations are approved.

Membership Decalcomanias—It was reported that some members cars have been refused inspection because of the way the membership decalcomanias were placed. This occurred in spite of assurance from the Division of Motor Vehicles that it was permissible to "display the decal on either the rear window or the rear side window." The council *recommended* that:

(1) Through our liaison with the Division of Motor Vehicles, MSNJ ask that the decals be honored in the interest of recognizing an M.D. in an official or emergency situation.

(2) The Division make an official declaration concerning the placement of the decals, to be circulated among the inspection stations.

(3) The Division permit the use of the degree of M.D. on the driver's license card.

Action: The recommendations were approved.

WORKMEN'S COMPENSATION

At the meeting of the Special Committee on Workmen's Compensation, March 11, 1962, attention was given to the following excerpt from a report on the AMA Congress on Occupational Health, referred to the special committee by the Board of Trustees:

Those in attendance at the AMA Congress generally believed that:

1. In compensation cases the employer who foots the bill should retain the right to select and designate the diagnosing and treating physician.
2. The amount of compensation awarded is a legal and *not* a medical problem.
3. Impairment and desirability should not be considered identical. "Impairment is anatomic or functional alteration from normal; disability is the absence of ability to do certain things."

The committee noted that the Trustees emphasized the policy of the AMA, "which this Society has repeatedly endorsed, that every individual should have the free choice of physician." But the committee endorsed the position of the AMA Congress: that in compensation cases the employer who foots the bill should retain the right to select and designate the diagnosing and treating physician.

However, it was emphasized that even though the employer designates the diagnosing and treating physician the employee still has the right of free choice of physician in that, if the physician selected by the employer is not satisfactory to the employee, the latter can select his own physician. The employee then becomes responsible for medical expenses above the amount which would be paid by the workmen's compensation insurance carrier. On this basis the committee went on record as endorsing the policy of the AMA and the Medical Society that all individuals should retain the right of free choice of physician.

The committee recorded its agreement with the AMA Congress on points number two and number three.

Action: This report is accepted.

NURSING EDUCATION

As the next step in stimulating recruitment of nurses, a fact finding meeting was called by the Committee on Nursing Education of representatives from the New Jersey Hospital Schools of Nursing. The directors of the schools and their assistants were invited, and 53 representatives from 27 schools were present.

Prior to the meeting a questionnaire on nursing education was sent to the directors of the 35 schools. Seventeen replies were received and these were the basis of discussion at this fact finding meeting. However, it was learned that the State Nurses' Association had called a meeting because of its belief "that a crisis has arisen." The group was assured that neither the Medical Society nor the special committee has the desire to usurp, or diminish, the power or function of the State Nursing Association in the area of nursing education in New Jersey. The purpose of the committee is merely to offer the assistance of the medical profession in solving the problem of the shortage of nurses in New Jersey.

The next step to be taken by the committee will be to arrange a joint meeting of "delegates" from the nursing schools, representatives of the Hospital Association, the Nurses' Association, and the State Department of Education. It is planned to call this joint session in the not too distant future.

During the discussion it was learned that the New Jersey State Nurses' Association does not carry out a recruiting program but that, with financial help from the Association, the New Jersey League for Nursing does. A past-president of the New Jersey League for Nursing, Miss Allen, suggested that the chairman of the Medical Society's special committee become a member of the New Jersey League for Nursing, since as a member he would receive the literature from the national organization which would keep him abreast of advances in the nursing profession.

The following *recommendation* was adopted by the special committee: That the chairman of the Special Committee on Nursing Education apply for membership in the New Jersey League for Nursing ($15 per year) and that the members of the committee be urged to take out membership if they so desire.

Action: The recommendation is approved with indication that the Society would pay the membership fee for the committee chairman.

GROUP HEALTH INSURANCE

As requested by the Board, Mr. Backes studied the complaint filed in Superior Court by GHI against the Commissioner of Banking and Insurance and the Attorney General. The action asks the court to determine the constitutionality of certain sections of the Medical Service Corporation Act—the requirement that nomination of trustees of any medical service corporation must be approved by a recognized medical society or professional medical organization having not less than 2,000 members holding licenses to practice medicine and surgery, and which has been incorporated for a period of not less than ten years; and the requirement, as a condition precedent to the issuance by the Commissioner of a certificate of authority to solicit subscribers and enter into contracts, of 51 per cent of the eligible physicians in any county as participating physicians.

MSP is reluctant to intervene because of the public relations involved. Mr. Backes stated that the Society also has a public relations concern and that it was his feeling that it would be inadvisable for the Society to be joined as a party. It was his advice that the Society apply to intervene only if there is assurance that its interests could not otherwise be properly protected. It was Mr. Backes' opinion that he should continue to work through the Attorney General, if the Board so wishes, rather than to petition for the right to intervene.

Action: The Board will grant power to Mr. Backes to continue to work through the Attorney General in this matter.

In response to the Board's letter reporting its actions concerning the GHI complaint, a letter from MSP stated that the Plan's Trustees were in accord with the actions taken by the Trustees of the Medical Society and, in consequence, had referred the matter to the Plan's legal counsel for appropriate implementation.

RESIGNATION OF DR. WARE

In a letter to the Board Dr. Carl Ware stated that "the period following my recent illness has taught me that I could not give to the office of President all that is needed. This is not the time for a job to be done only partly." The letter offered Dr. Ware's formal resignation from the office of First Vice-President, his tenure to terminate at a time most convenient to the Society. Dr. Ware asked that it be recorded that his resignation is tendered with deep regret, but in the best interest of our Society. He expressed a desire to continue to serve the Society, but in some capacity where the demands are a little less and the pace a little slower.

Action: Dr. Ware's letter will be received with sincere and deep regret. The Board accepts his resignation as First Vice-President at the close of

sessions of the House of Delegates at the 196th Annual Meeting next month. The Executive Officer will draw up, in the name of the Board, an appropriate set of resolutions thanking Dr. Ware for his many services to The Medical Society of New Jersey.

TEMPORARY DISABILITY BENEFITS

In a lengthy communication from the Division of Employment Security, State Department of Labor and Industry, the problem regarding prompt and timely payments of temporary disability benefits claims for covered workers was outlined. The role of the physician is essential under the statutes, and in the various administrative requirements of the agencies paying benefits under this program. While the bulk of physicians have willingly accepted the requirements, all physicians are urged to complete the simple, brief forms.

Action: It was directed that the matter be published in THE JOURNAL and/or the *Membership News Letter* for the information of the membership.

AMA MEETING ON OCCUPATIONAL HEALTH

Recommendation from the Special Committee on Industrial Health was that the Board of Trustees be requested to authorize the chairman or a member of the Special Committee on Industrial Health to attend this conference in Washington, D. C., on May 19, 1962, with expenses paid.

Action: This recommendation is approved.

MSP LIAISON COMMITTEE

The MSP Board proposes that a committee consisting of four members from MSP and four members from MSNJ Board of Trustees be appointed for the purpose of discussing problems that arise from time to time, which may be of common concern to the Plan and the Medical Society. The following were appointed to represent MSP: Dr. Schaaf, Dr. Donnelly, Dr. White, and Dr. Alfano. It was further proposed that the best interests of both organizations would be served if committee members chosen from the Board of Trustees of MSNJ were not also members of the Board of Trustees of MSP.

Action: The President and Chairman of the Board are empowered to appoint four doctors to the liaison committee who are not members of the Plan Board.

May 11, 1962

Following is a resume of significant actions of the Board of Trustees, taken at its May 11 meeting:

National Blue Shield Senior Citizens Program . . . reaffirmed its action taken at the April meeting to "approve in principle the proposed National Blue Shield Citizens Program" and to "approve the Professional Services Index and the conversion factors as submitted. . .", in light of a recommendation from the National Association of Blue Shield Plans "that the method of rating and administering the Blue Shield National Senior Citizens Program be changed to local rating and local administration."

Seton Hall Chapter, Student AMA . . . in accordance with precedent of last year—authorized a $100 contribution to send Chapter representatives to the 1962 SAMA Annual Meeting in Washington, D.C., May 9-12.

Carl N. Ware, M.D. . . . adopted the following resolution concerning Dr. Ware's resignation as First Vice-President.

CARL NASH WARE, M.D.

Whereas, because of recent serious illness, Carl Nash Ware, M.D., has submitted his resignation as First Vice-President of The Medical Society of New Jersey, impelled by his conviction that the demands of the Presidency would be beyond the limits of his health and strength; and

Whereas, the Board of Trustees, bowing to his decision, has accepted Doctor Ware's resignation with sincere and deep regret; and

Whereas, in so doing the Board of Trustees realizes thereby that The Medical Society of New Jersey will be deprived of a President of whom it would well and truly have been proud; therefore be it

Resolved, that the Board of Trustees convey to Dr. Ware their grateful appreciation of his high

character and of his distinguished services to The Medical Society of New Jersey; and be it further

Resolved, that the Board of Trustees encourage Dr. Ware to make himself available, for the good of The Medical Society of New Jeresy, to serve in such lesser capacities as will not tax or endanger his continued good health; and be it further

Resolved, that a copy of this resolution be spread on the minutes of the Board of Trustees and be presented to Dr. Ware with the thanks and good wishes of all his colleagues.

Medicare Program . . . authorized the committee chairman to sign the "Contractors' Statement of Contingent or Other Fees," certifying that MSNJ has not employed, retained, or agreed to pay other than full-time Society employees as a result of the contract between the government and the Society.

New Jersey State Safety Council . . . received and noted a report acknowledging MSNJ's help in achieving its objective of $600,000 to finance the council activities for three more years.

New Jersey Blood Bank Commission . . . reaffirmed its $250 budgetary allotment approved by the Finance and Budget Committee—in considering a new request from the Commission for an increase to $500.

MSP Press Release Letterhead . . . received and noted from MSP acknowledgement and adoption of MSNJ's recommendation that "press releases having to do exclusively with MSP or HSP be issued on the single letterhead of the Plan involved."

May 15, 1962

Following is a resume of significant actions taken by the Board at its reorganization meeting on May 15, in Atlantic City:

1962-63 Chairman and Secretary . . . elected Dr. Samuel J. Lloyd (Mercer County) chairman; and Dr. Nicholas E. Bertha (Morris County) secretary of the Board for the year.

Finance and Budget Committee . . . elected Dr. Joseph R. Jehl (Passaic County) trustee-member, for a term of three years.

1962 AMA Meeting . . . designated Dr. Jehl as alternate-delegate, to attend the June meeting with expenses paid, together with the president, the president-elect, and the executive officer.

Salaried Personnel . . . reappointed for 1962-63 —at the salaries set forth in the adopted budget—all salaried personnel, including legal counsel and the legislative analyst.

Board Meeting Schedule . . . agreed to hold meetings regularly at 10:45 a.m. on the third Sunday of each month, subject to cancellation should business prove insufficient.

House of Delegates Referral . . . directed that a communication be sent to component societies from the president, informing them that: "In view of the generally favorable and adequate reflections of the actions of the House of Delegates in the press, it would not be necessary at this time for MSNJ to launch a paid advertising campaign, as authorized by the House at its closing session."

Correspondence . . . noted telegrams and other correspondence received by the president, endorsing the Society's action on the King-Anderson Bill . . . directed that a reply be sent to Governor Hughes, in response to a news release and telegrams from the Governor announcing the withdrawal of A-755.

Action for Mental Health

The much-discussed report, *Action for Mental Health, has been* reviewed by the American Psychiatric Association. Copies of that Association's position on this report may be obtained without charge by writing to Medical Director, American Psychiatric Association, 1700 N.W. 18 Street, Washington 9, D. C. Ask for: A.P.A. position on *Action for Mental Health*.

Blue Shield and Blue Cross for College Students

Hospital Service Plan of New Jersey (Blue Cross) and Medical-Surgical Plan of New Jersey (Blue Shield) now offer hospital and medical coverage at reduced rates for full-time students in colleges and other accredited schools of higher education. These contracts offer realistic health care protection during an academic career at low cost, made possible because of the generally good health of college students.

The student coverage will be effective at monthly rates of $2.85 for Blue Cross and $1.08 for Blue Shield, representing a total of $3.93 for the health care package. Subscriptions will be payable quarterly at $11.79.

The new contracts are available to New Jersey residents (regardless of age) who are enrolled as full-time students in any accredited college, university, junior college, trade or business school or industrial education center; and to out-of-state residents who are full-time students at such institutions in New Jersey.

Eligibility will not be impaired by a student's employment during regularly scheduled school vacation periods, so long as he is not employed full-time during the school year. Enrolled students will be covered anywhere, on or off campus, on a year-round basis.

No health statement is required of applicants, nor is there a limitation on pre-existing health conditions. Married students may enroll individually. No materity coverage is provided. Also excluded are care for injuries sustained in interscholastic or intercollegiate athletics or in non-commercial flying. Otherwise, this provides the same hospitalization and medical-surgical coverage available under Comprehensive Blue Cross and the basic Blue Shield contracts.

Heretofore, only the regular direct enrollment coverage has been available to college student children of Blue Cross and Blue Shield family contract subscribers when they reach age 19. With the new plan a student covered under a family contract who reaches age 19 may apply for a student contract, thus providing uninterrupted coverage at low rates throughout the rest of his academic career. Full-time students now holding individual contracts with the plans may apply for transfer to the lower-cost student coverage.

Application forms may be obtained from Blue Cross and Blue Shield, 500 Broad Street, Newark, or 130 North Broadway, Camden, or from 28 West State Street, Trenton. Closing date will be annually in February and September.

Hospital Planning

Dr. Brian Abel-Smith, writing in the May 1, 1962 *Hospitals*, discusses the problem of planning hospital beds. Dr. Abel-Smith is Chairman of the Planning Committee of the Metropolitan Regional Hospital Board in England.

"One problem in long-term planning is appraising the bed need. During World War II, English hospital experts estimated bed need at 5 per thousand population; but extensive studies since then have shown the need at little more than three acute beds. The need varies between different areas of the country and can vary rapidly over time as medical technics and medical fashions change.

"Areas which already had fewer beds seemed to need fewer beds, while those having more beds needed all the beds they had. Despite all the talk about haphazard hospital development, it appeared that supply was nearly equal to demand.

"What we had discovered was *Say's law*. Within limits, supply creates its own demand. When general practitioners know that hospital beds are short, they don't hospitalize patients who are not desperately in need . . . When hospital doctors know that beds are short, they reduce the length of stay. When they know they are plentiful, they increase the length of stay.

"Statistical studies provide useful yardsticks in planning, but they must be used with common sense. A compromise must be worked between the demand for beds as calculated by statistics and the demand expressed by physicians and citizens of the region. Hospital planning must also be done within the framework of all medical and social services."

AMA Position on Narcotic Addiction

On May 14, 1962, the American Medical Association released an account of its position on narcotic addiction. The following extracts are from that release.

"Society has found it necessary to employ legal controls to prevent the spread of certain types of illness that constitute a hazard to public health. Drug addiction is such a hazard.

"The successful and humane withdrawal of individuals addicted to narcotics in the United States necessitates constant control, under conditions affording a drug-free environment, and always requires close medical supervision.

"The successful treatment of narcotic addicts in the United States requires extensive post-withdrawal rehabilitaton and other therapeutic services.

"The maintenance of stable dosage levels in individuals addicted to narcotics is generally inadequate and medically unsound and ambulatory clinic plans for the withdrawal of narcotics from addicts are likewise generally inadequate and medically unsound.

"We support (1) after complete withdrawal, follow-up treatment for addicts, including that available at rehabilitation centers, (2) measures designed to permit the compulsory civil commitment of drug addicts for treatment in a drug-free environment, (3) the advancement of methods and measures towards rehabilitation of the addict under continuing civil commitment, (4) the development of research designed to gain new knowledge about the prevention of drug addiction and the treatment of addicted persons, and (5) the dissemination of factual information on narcotic addiction.

In this connection, Mr. Henry L. Giordano, Acting Commissioner, U. S. Bureau of Narcotics, issued the following statement:

"The Bureau of Narcotics supports the five measures set out in the last paragraph. This will provide addicted persons with the best possible rehabilitative treatment programs and reduce, and if possible, eliminate narcotic drug addiction.

"The Bureau of Narcotics subscribes completely to the view that federal law does not consider drug addiction a crime."

Citation to Dr. Read

Hilton S. Read, M.D., Director of the Ventnor Diagnostic Center and Executive Director of the Ventnor Foundation, was awarded an Honorary Degree of Doctor of Laws by Swarthmore College on June 11, 1962. The citation read, in part:

Upon the recommendation of the Faculty and the Board of Managers, I present, for the degree of Doctor of Laws, Hilton S. Read. A graduate of Rutgers University, the University of Pennsylvania, and the Jefferson Medical College, he is a dedicated practitioner and educator in medicine. Through his understanding and determination the Ventnor Foundation was established with the simple challenging purpose of helping to "wage peace" by promoting international understanding and brotherhood through the training of doctors from abroad.

Since 1961, when the Foundation's work began, Dr. Read has been responsible for bringing more than 600 promising young doctors from Germany, Austria, Switzerland, Yugoslavia, and Poland to this country to receive further education through rotating internships in our hospitals. Dr. Read and his associates try to see that each young doctor experiences, in addition to medical training, something of the scope and variety of American life.

It is Hilton Read's generosity, his determination, his thoughtfulness, and his kindliness that have made the work of the Ventnor Foundation so successful a contribution to both medical education and international understanding. In awarding the degree, President Smith read the following citation: "Hilton Read, public-spirited practitioner of medicine who has written prescriptions that embrace not only the health of a patient but the welfare of a troubled world, it is my privilege to confer upon you, by the authority vested in me by the board of Managers of Swarthmore College and by the Commonwealth of Pennsylvania, the degree of Doctor of Laws, and to admit you to all the rights and privileges of that degree."

Letters to The Journal • • •

Senior Citizens or Political Pawns

Dear Sir:

As a dues-paying member of the AMA, I'm glad to be a part of a group that still has the courage to raise its voice against a part of the public being bilked. "Medicare," or hospital and nursing home care under Social Security, has the potential wallop of dynamite for the Congress and the country. Commercial or not, no one's going to vote against Mother's Day, and "Medicare" is being billed in the same class. President Kennedy—along with a formidable group of speech writers, publicity experts, pamphlet producers, lobbyists, and a sizable hunk of taxpayer money—is pushing the King-Anderson Bill with supersonic speed; and the old folks are on the receiving end of the Administration's biggest sell—so much so that many deluded elders are under the impression that false teeth, eye glasses, and wooden legs are all part of the deal.

Fact is, if this bill does pass there are going to be a lot of downright disillusioned people, relatives included. Pawning off grandma on the government may seem a happy solution to many a multiple family, but better not count your chickens too soon. Seems a lot of our elder population aren't even covered by the bill, and for those who are it isn't "for free." Social Security insurance not being insurance at all, according to the Supreme Court, as assets of 20 billion and obligations of about 300 billion; hardly the type of financial statement to encourage the most inept investor. To underwrite the King-Anderson Bill billions more would be needed from the already over-taxed young folks and the overburdened old folks. In fact, "Medicare" tax money would be spent as fast as it came in for some 14.7 million people who never contributed at all.

Are doctors really against hospital and nursing home care for old folks? You bet they're not, and our profession has proved it many times over by freely contributed service in hospitals, clinics, and health programs of every kind without recompense or desire for it. More over, every doctor has those special patients whom he carries either without charge or at a minimum. Sometimes these patients are young; more often they are the old and in a low income group. Every doctor feels this obligation for service and takes pride in its accomplishment. For the American physician—who has less financial security than any comparable group; is not covered by workmen's compensation, unemployment insurance, sickness benefits or social security, and works an eighty, not a thirtfy-five hour, week—this is merely part of being a doctor.

If we are going to help our elder citizens, let's not start with deceit and misleading advertisement by our government. Certainly we all want the real facts; and if the dignity or health of our senior citizens is threatened through need or sickness, then they deserve and merit the help of us all. To preserve and secure the highest standard of medical care for the people of the United States is the primary purpose of the American Medical Association. Doctors, however, are not politicians, and deal in facts not constituents. To endorse the King-Anderson Bill in its present form would be a violation of public responsibility by the medical profession and a gross disservice to our senior citizens.

ROBERT B. MARIN, M.D.

Watch Those Disposable Syringes!

Disposable syringes are being found in trash receptacles and have been found in possession of drug addicts. The problem this creates for law enforcement officers is apparent. Addicts know that these items may be disposed of in trash receptacles without being destroyed and will go to considerable efforts to secure them after they have been discarded. The availability of these valued items to drug addicts defeats, to some extent, our hypodermic needle statute. It is urged that disposable syringes including the needle and barrel be destroyed after being used.

Destruction should include breaking the needle from the hub, breaking the nipple off the barrel and breaking the plunger; and wherever feasible destruction of the remnants by burning.

The cooperation of all persons and institutions in destroying disposable syringes (including the needle and barrel) will aid law enforcement by preventing these units from falling into the hands of persons who would misuse them, and will make an important contribution to control the illicit use of narcotics.

Psychosomatic Profile • • •

From time to time, THE JOURNAL will publish in this space an item on psychosomatics of interest and importance to all medical practitioners. Contributions are invited and should not exceed 500 words each.

The Hyphen in Psycho-Somatic

As every medical student knows, Beaumont, in 1833, observed changes in the gastric mucosa through St. Martin's fistula. He saw that emotions actually caused physical and chemical changes in body structures. This was not considered a particularly epoch-making observation, since the connection between mind and body had always been taken for granted in primitive medicine. (What then are witch doctors?) Yet, in a sense, this *was* a history-making experience, because it did demonstrate by cold scientific observation that the emotions were linked to body chemistry and body structure.

The sympathetic nervous system prepares the body for fight or flight in emergency situations. Because of sympathetic stimulation, blood pressure rises, carbohydrates are mobilized, blood is driven from the splanchnic region to the brain and the muscles. Repressed hostility and self-assertiveness will produce (according to Alexander[1]) neurogenic hypertension. The parasympathetic system is, to the contrary, stimulated in emotions leading to dependency and withdrawal from external problems. Alexander[1] calls these states "vegetative retreat." "Vegetative retreat" involves chiefly the gastro-intestinal system and produces hyperacidity, peptic ulcer, colitis, diarrhea and bloating. I recently saw two women who had extreme bloating with marked abdominal distension. In one, the bloating occurred each time she felt alone and abandoned.

The neural substrate of emotions was investigated by Papez,[4] McLean,[5] Penfield,[6] Bard,[2] Masserman[3] and others. Papez[4] and then McLean[5] postulated that the older rhinencephalic (olfactory) structures incorporated in the limbic lobe in man do not subserve olfaction but are the anatomic basis for elaboration of feeling tone. The rhinencephalic structures are connected on one hand with the frontal cortex and on the other hand with the hypothalamus. The frontal cortex elaborates and refines the cruder feeling tone produced by rhinencephalon. The hypothalamus, being, among other things, the center of the autonomic nervous system, acts as the effector organ of emotions. Bard[2] and Masserman[3] succeeded in producing sham rage in cats through stimulation of the posterior part of hypothalamus. Rage lasted as long as hypothalamus was being stimulated and ceased with the cessation of stimulation. Masserman[3] indicates that neocortical areas are necessary for full elaboration of the feeling tone and of emotions. This implies that the emotional experience as we perceive it depends on complex interrelationship of all the parts of the brain.

In psychiatric practice, we deal increasingly with the *emotional* component through psychotherapeutic measures. We do this more than we deal with the neural substrate through physical or chemical means. We know that diseases such as peptic ulcer or ulcerative colitis are often emotionally induced. Yet treatment of such conditions should not be entirely the responsibility of a psychiatrist. It should be a cooperative effort with the internist and the surgeon, whose role is to handle the somatic effect of the emotionally induced autonomic dysfunction.

EUGENE REVITCH, M.D.

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1. Alexander, F.: *Psychosomatic Medicine.* New York, 1950, Norton.
2. Bard, F.: American Journal of Physiology, 84:490 (April 1928).
3. Masserman, J.: *Behavior and Neurosis.* Chicago, 1943. University of Chicago Press.
4. Papez, I. W.: Archives of Neurology and Psychiatry, 38:725 (August 1937).
5. McLean, P. D.: Electroencephalography and Neurophysiology, 4:407 (June 1952).
6. Penfield, W. and Jasper, H.: *Epilepsy and Brain Anatomy.* Boston, 1954, Little Brown.

County Society Reports • • •

Gloucester

The *Gloucester County Medical Society* met on April 19 at the Woodbury Country Club, with President Rudolph T. DePersia in the chair. Twenty-six members were present, together with members of the local bar association. The meeting was addressed by William A. Steadman, President of William Allen Steadman & Company of East Orange. The topic was "Dollar Delirium." He presented graphic illustrations of the use of money for future security.

Following refreshments, the president called the business session to order.

Dr. George R. Booth, treasurer, reported a substantial balance. He requested clarification of dues for associate members and their pro-ration, depending on time of acceptance as members.

The program committee for 1962-63 was named: Drs. Puff, Lovelace, Hutcheson, and Jaggard. Dr. Patterson, AMA Delegate, reported that the California College of Osteopathy is now accredited, and its June graduates will receive M.D. degrees.

Dr. Flynn was given a vote of thanks for his excellent work in promoting the understanding of the Kerr-Mills Law and urging its passage in this state. Many articles have appeared in our local papers.

Our executive secretary, Mrs. Chew, offered to go to the State Society headquarters, hoping to clarify and correct our membership listing.

Dr. A. Guy Campo was appointed nominating committee chairman.

The meeting adjourned at 12:10 p.m.

On May 17, with Dr. Rudolph T. DePersia presiding, the *Gloucester County Medical Society* met at the Woodbury Country Club. Twenty-four members were present. Guests at this meeting were members of the Woman's Auxiliary.

"What's New in Research?" was the scientific program. Panel participants were members of the Alumni Association of Jefferson Medical College. Dr. Gerald Dodd presented "What's New in Surgery?"; Dr. Ralph Carabasi, "What's New in Radiology?"; Dr. Thomas Nealon, Jr., "What's New in the Medical Treatment of Cancer?"

We then heard reports from the treasurer, Dr. Booth; Judicial Committee, Dr. Flynn; Legislative Committee, Dr. Campo; Contact Committee, Dr. Flynn; and our trustee, Dr. Collins.

The report of the nominating committee was adopted. It follows: *President*, Dr. Francis M. Brower, III; *Vice-President*, Dr. Harry B. Lochhead; *Secretary*, Dr. Cornelius Regan; *Treasurer*, Dr. George R. Booth; *Reporter*, Dr. Dorothy M. Rogers; *Executive Secretary*, Mrs. Marian F. Chew.

Delegates: Drs. William T. Beall, three years; A. Guy Campo, two years; Thomas Flynn and Rudolph T. DePersia, one year. Alternates: Drs. Dorothy M. Rogers, three years; Don B. Weems, two years; Drs. Francis M. Brower and Cornelius Regan, one year.

State Nominating Committee Delegate, Dr. A. Guy Campo; Alternate, Dr. William T. Beall. Censors: Drs. Thomas F. Flynn, thee years; William T. Beall, two years; Fred G. Wandall, one year.

Trustees: Drs. Chester I. Ulmer, three years; Herman W. Wright, two years; S. Thomas Camp, one year.

The following suggestions were submitted by the nominating committee: 1) that the Gloucester County convention room in Atlantic City for the meeting of The Medical Society of New Jersey be financed for the delegates and membership by the county society each year. 2) that the Gloucester County Medical Society increase the salary of the executive secretary by $10 each month.

The nominating committee membership was Drs. William T. Beall, A. Guy Campo, Isaac N. Patterson, and Don B. Weams, Sr.

It was recommended that associate members attend 50% of the meetings; and that the society allot $30 per day for five days for a room in Haddon Hall at convention time.

Fluoridation of public water supplies was discussed by Dr. Palmer, and officially endorsed by our Society.

Drs. Kehler, Beall, and DePersia were appointed to revise the Constitution and Bylaws.

Following refreshments, the meeting adjourned.

DOROTHY M. ROGERS, M.D.
Reporter

Salem

Dr. Wilbert R. Staub was installed as president of the *Salem County Medical Society* on May 19, at a dinner party in the Sakima Country Club, Penns Grove. Over 75 members and guests were present. Honored guests were Dr. Ralph Buchanan, retiring State Society president, and his wife. Dr. William Sprout, before turning the gavel over to Dr. Staub, thanked his executive committee for helping to make his year at the Society's helm a successful one. Special thanks were given to his wife, for bearing with him during the past year. Drs. Frank Winters, Joseph Fishbein, and George Nitshe were cited for planning the most entertaining annual dinner the society has had.

Other officers for the year 1962-63 were introduced: vice-president, Dr. Philip Boyer; secretary,

Dr. George Reichwein; treasurer, Dr. Donald McLean; reporter, Dr. John T. Dooley.

The guest speaker was Louis P. Shannon of Wilmington, Delaware, head of DuPont's Speaker's Bureau and former School Administrator, who gave an intriguing talk on "The Disappearance of the Obvious."

JOHN T. DOOLEY, M.D.

Reporter

Widows and Orphans

At the annual meeting of the Society for the Relief of the Widows and Orphans of Medical Men of New Jersey held on June 8, 1962, the following officers were elected: *President*—James E. D. Gardam, M.D.; *Vice-President*—Berthold T. D. Schwarz, M.D.; *Treasurer*— George F. Stoll, M.D.; *Assistant Treasurer*—Ogden Carter, M.D.; *Secretary*—Joseph W. Gardam, M.D.; *Custodian of Permanent Fund*—Herbert A. Schulte, M.D ; *Counsel*—Charles Hardin.

The following trustees were re-elected for a three-year term: A. J. Gordon, M.D.; George Potekhen, M.D.; Joseph Jehl, M.D.

Financial statement showed the following:

Balance on hand May 1, 1961	$10,079.89
Receipts	20,592.71
Expenditures	17,668.20
Balance on hand May 1, 1962	$13,004.40

New members during the year — 43

Members lost through death, resignation and nonpayment — 43

Total membership April 30, 1962 — 769.

J. W. GARDAM, M.D.

Secretary

The New Jersey Allergy Society

At its annual meeting on May 23, the New Jersey Allergy Society elected for the year 1962-63 the following officers: *President*, Dr. Francis A. Pflum; *Vice-President*, Dr. Aaron Weiner; *Secretary*, Dr. William I. Weiss; and *Treasurer*, Dr. Edward Pickert.

New Jersey Gastroenterological Society

The New Jersey Gastroenterological Society, at its annual meeting in Newark on June 13, heard a paper by Dr. Carroll M. Leevy on "Liver Regeneration."

At the business session the following officers were elected for 1962-63: *President*, Dr. Louis A. Brodkin; *President-Elect*, Dr. Leo Siegel; *First Vice-President*, Dr. Herbert Greenfield; *Secretary*, Dr. Harry B. McCluskey; *Program Chairman*, Dr. Victor Groisser; and *Treasurer*, Dr. Jacob Riese.

Announcements

Be Alert to Medical Imposters

From time to time swindlers present themselves as physicians and apply for hospital or office appointments. Sometimes they use the credentials of deceased physicians. Sometimes they use stolen credentials. Sometimes they forge credentials or offer none at all.

One such imposter—who is an ex-convict—is now working in the Midwest, where he poses as Walter Carl Schmid, M.D., or Walter E. Anderson.

His real name is James Walter Brewen.

Physicians who are asked to help find places for American-trained doctors looking for a change are warned to compare the pictures on the credentials with the person presenting them, and to communicate with the state medical society of the applicant's last residence.

Basic Science Course

The New York Academy of Medicine has available a course in basic sciences, to be held every Tuesday evening starting September 11, 1962 and terminating April 30, 1963. While advance registration is required, there is no tuition fee. The program is given at the New York Academy of Medicine, 2 East 103rd Street, New York, New York.

The schedule covers a basic review of all the human organ systems with emphasis on physiology, pharmacology, and biochemistry. All the material is related to clinical practice. A star-studded faculty has been enlisted.

For a full program and a registration blank, write to Committee on Medical Education, New York Academy of Medicine, 2 East 103rd Street, New York 29, New York.

Obituaries • • •

DR. EDWARD FENDRICK

Dr. Edward Fendrick, one of the state's pioneer pathologists, died of a coronary attack on June 4. Born in Pennsylvania in 1900, he received his M.D. at the University of Pennsylvania in 1925. After his internship he accepted a residency in pathology at the Philadelphia General Hospital, and came to East Orange, one of the earliest residency-trained pathologists in the area. He was pathologist at the Essex County Sanatorium in Verona and director of laboratories at the Rahway Hospital. Dr. Fendrick was a Fellow of the American College of Pathologists, and an active member of the Essex County Medical Society.

DR. MARTIN A. JOYCE

At the untimely age of 38, Dr. Martin A. Joyce, a Trenton practitioner, died at the Point Pleasant Hospital on May 20, 1962. Born in Trenton. Dr. Joyce spent his childhood in Manasquan, and was graduated from the high school there. He received his M.D. at the Georgetown University Medical School in Washington. He was affiliated with the St. Francis Hospital in Trenton, but was living in Manasquan at the time of his sudden death.

DR. LOUIS LANG

One of Union County's senior general practitioners died on June 10 with the passing that day of Dr. Louis Lang. Born in Austria in 1893, he was graduated in 1919 with an M.D. degree from the University of Budapest. During World War I he served in the Imperial Austro-Hungarian Army. In 1939, Dr. Lang moved to the United States, practicing first in New York City—and, since 1942—in Elizabeth, N. J., where he carried on an extensive family practice. Dr. Lang was on the staff of the Elizabeth General Hospital and was active in committee work with the Union County Medical Society.

DR. SIDNEY PENDEXTER

One of New Jersey's first ophthalmologists died on June 6 with the passing that day of Dr. Sidney Pendexter. Dr. Pendexter was 76 years old at the time of his death. A native of Maine, he was graduated in 1909 from the medical school of Bowdoin College. He was interested from the start in ophthalmology and otolaryngology and in 1911, at the age of 26, became director of the old "Throat and Lung Hospital" in Manhattan. In 1914 he came across the river and settled in East Orange, whose people he served for half a century. Dr. Pendexter was a Trustee of the Munn Avenue Presbyterian Church and, having served in all other grades, became a consulting ophthalmologist at the Orange Hospital Center. He was also affiliated with the Manhattan Eye and Ear Hospital and was on the staff of the Newark Presbyterian and East Orange General. He was a member of our Essex County Medical Society.

DR. MICHELE TOMAIUO

A heart attack on June 12 took the life of Dr. Michele Tomaiuo of North Bergen, past-president of the medical staff of the Christ Hospital of Jersey City. Born in 1899, he received his M.D. from the University of Maryland in 1926. He came to the United States in 1912 where his parents settled in Hoboken. In 1923 he received a baccalaureate degree at Fordham, and after getting his M.D. degree he accepted a surgical internship at St. Joseph's Hospital in Baltimore. He then did graduate work at Columbus Hospital in New York City, and came to Hudson County, New Jersey. He served the people of that county for 30 years, and rose through the ranks in all grades of the surgical service at the Christ Hospital in Jersey City. Dr. Tomaiuo was a Fellow of the American College of Surgeons.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

The Story of X-Rays from Roentgen to Isotopes. By Alan R. Bleich. New York, 1961, Dover. Pp. 186. Paper. ($1.65)

The Senator from Somerset County, New Jersey introduced into our legislature, in 1896, a bill to prohibit the use of x-ray opera glasses in theatres. He was afraid the prurient theatre goers might use the newly discovered rays to pierce through the clothing and corsets of the stars. Some great discoveries take a long time to be recognized. But roentgen rays hit the world with a bang.

This modestly-priced book is a lively and non-technical account of the way radiation has affected our lives. It discusses in dramatic fashion the discovery of x-rays. It reviews the medical, industrial, technologic and criminologic use of roentgen rays. Its dangers are also emphasized. There is an all too brief account of radiation outside of that produced by x-ray equipment. Isotopes, atom bombs and fall-out get very scant mention.

This robustly bound paperback will be of interest to any medically curious and intelligent layman. It will help the physician prepare talks to the public and will assist the radiologist in answering queries from non-specialists.

ABRAHAM LEFF, M.D.

Mechanisms of Disease: An Introduction to Pathology. By Ruy Perez-Tamayo, M.D. Philadelphia, 1961, Saunders. Pp. 512 with 225 illustrations, 72 tables and (believe it or not) 2,719 references. ($14.00)

Traditionally, pathology has been a static science. It dealt with dead tissue that could change no more. In the last few decades, however, pathologists have put more emphasis on dynamic or physiologic pathology, on a concept of disease as "life under abnormal conditions." In this compact, highly readable volume the author portrays disease processes as dynamisms. He writes fluently, vividly, and interestingly. The chapter on tumor alone is worth the price of the book. Dr. Perez-Tamayo considers general processes such as inflammation, repair, degeneration of tissues and so on. He then takes up host-parasite relations, the pathology of connective tissue, the immune response, metabolism, nutrition, and the pathophysiology of body fluids and electrolytes. An epilogue on "The Nature of Disease" offers a mellow, well-rounded, philosophical, historical and conceptual treatment of the disease process itself. This is one of the few texts I have seen that makes pathology seem glamorous.

VICTOR HUBERMAN, M.D.

Antony von Leeuwenhoek and His Little Animals. Clifford Dobell. New York, 1961, Dover Publications. An unabridged reprinting of the 1932 hardcover. Pp. 435. Soft covers. ($2.25)

An uneducated Dutch draper with the awkward name of Antony von Leeuwenhoek learned how to assemble microscopes in the early 17th century. Through them he was the first to discover the "little animals." Leeuwenhoek's microscopes were better than those made anywhere else in the world at this time; and it was only through this superior instrument that the animalcules could be seen. Thus was opened the door to the microcosmic world. Leeuwenhoek never wrote a book: not even a scientific paper. But he kept sending his observations to the Royal Society of London. This book collects his major letters, includes many illustrations, biographic notes, elucidations, bibliographic references and narratives of that germinal period in the history of science. Leeuwenhoek, remember, was the man who first saw protozoa, erythrocytes and spermatozoa. Perusing this highly readable volume gives you a ringside seat at one of the most exciting periods in the expansion of man's knowledge of his universe.

DAVID HENRY, M.D.

Textbook of Biochemistry. By. E. S. West Ph.D. and Wilbert Todd, Ph.D. Ed. 3. New York, 1961. Macmillan. Pp. 1421. ($16.75)

For ten years West and Todd has been a standard biochemistry text. At one time, the pharmacist was a "chemist" and the physician viewed the human body as a vast chemical laboratory. Increasing emphasis on the social and emotional aspects of medical practice has blurred the biochemical basis of life. In the last decade, however, a reverse trend has set in. Phenomenal developments in pharmacology have underscored the importance of biochemistry. Other factors have been increasing interest in enzymes, hormones, amino acids, phospholipids, antimetabolic agents and atomic medicine. West and Todd have kept pace and now offer a magnificent 1421 page cyclopedia of biochemistry. The text is brisk, business-like and somewhat pedestrian. But there is no fat in the book: it's all good meat. The practitioner may find too much mathematics and too many structural formulas here. But these are necessary in any solid work in biochemistry—and that describes this third edition.

FELIX A. UCKO, M.D.

Practical Pediatric Dermatology. Morris Leider, M.D. St. Louis, 1961, Mosby. Ed. 2. Pp. 437 with 117 illustrations. ($13.75)

This is a heavy and sturdy book—an unusual feature in this age of planned obsolescence. Each page is of heavy texture. This probably makes for better, clearer and more opaque photographs. The pictures are numerous, profuse and portray well the important and common diseases and their several varieties.

An attempt is made in each chapter to include conditions etiologically related. This is often difficult. The last chapter is a miscellany of rare and uncommon dermatoses each succinctly discussed in a paragraph or two. Each section is prefaced with a short descriptive outline so that one can spot a reference by page.

Many tables are presented of similar and/or related diseases featuring similar and differential features.

I find the book easy reading. The diction is free wheeling. The author is iconoclastic and unconventional in spots. When he doesn't know for a fact he isn't afraid to say so. He has covered the subject concisely but adequately with little room for theorizing, since he has aimed at a practical work.

Aside from a balanced and adequate diet, the author has little faith in dietary approaches to treatment. He feels the same about the psychiatric approach. I recommend highly this book both for pediatricians and general practitioners. Dermatologists will also find it well worth their attention.

WILLIAM J. SWEELEY, M.D.

Hospitals, Doctors, and Dollars. Robert M. Cunningham, Jr. New York, 1961. F. W. Dodge Corp. Pp. 268. ($6.95)

Mr. Cunningham, a public relations expert, has for some years been editor of *The Modern Hospital.* In this (obviously non-objective) view of American hospitals, he tries to penetrate the clouds surrounding such subjects as labor unions in hospitals, fee-splitting, Blue Cross, and administrator-staff conflicts within the hospital family. He subtitles his text: "Opinions on good samaritans who are having bad times." His touch is deft, but not clownish. Consider such chapter titles as: Washing Professional Linen in Public; Practice in Plastic Towers; Some of my Best Friends are Doctors; The Blue Cross Blues. Mr. Cunningham's views about us (doctors and nurses) are entertaining and edifying. What more can you ask for $6.95?

HENRY A. DAVIDSON, M.D.

Psychiatry: Biologic and Social. By Ian Gregory, M.D. Saunders, Philadelphia, 1961. Pp. 577, with 54 tables. ($10.00)

Psychiatry is a wordy discipline, and books and articles in this area appear with relentless frequency. One has a right, therefore, to ask of any textbook: What does this volume have that the others don't have? Gregory's *Psychiatry* devotes more space to social aspects of emotional illness than do the more traditional texts. There is, for example, a 13-page chapter on social therapy, and an excellent but compact section on forensic psychiatry. Gregory discusses marital problems, suicide, and prevention of mental illness. Also, unusual is a practical chapter on research methods and statistical technics. In general, the author tries to integrate pharmacologic, genetic, psychodynamic and social facets of psychiatry into a single volume. He has done very well (considering the relatively small size of the book) in touching on almost every phase of the subject. This book offers a good all-around review for the general practitioner and a useful first text for the senior medical student. And it won't hurt the practicing psychiatrist either.

HERBERT BOEHM, M.D.

A **Textbook of Medical Treatment.** Edited by Derrick Dunlop, Stanley Davidson and S. Alstead. Edinburgh, Scotland 1961, Livingstone. Available in USA through Williams and Wilkins, Baltimore. Eighth edition. Pp. 983. ($12.50)

For 22 years, British medical students and practitioners have used "Dunlop and Davidson" as a *vade mecum* of medical treatment. The current edition (the 8th) includes new material on geriatrics, electrolyte imbalance, steroid therapies, and chemotherapies. American readers may have slight difficulty with differences in drug names (barbitone, for example) or in disease terminology (rheumatism, for instance) but these semantic bottlenecks are not serious. Sometimes the approach may seem a bit odd, as in this swift way of disposing of the care of the marihuana addicts: "This addiction is best regarded as a vice to which the doctor has no right to pander." Most of the text, though, shows a higher level of sophistication than that. The book includes an excellent section on prescription-writing, fast becoming a lost art in the United States.

Every once in a while the reader becomes confused—or amused—by reference to British and Scottish paper work under the National Health Act. ("Prescriptions are written on form EC. 10, but in Scotland the doctor gets his own drugs through form EC-10-A," or "The District Rehabili-

tation Officer has the right of entry to any hospital.")

The book is divided into the conventional chapters—diseases of the endocrine glands, diseases of the nose and throat and so on. There is a section on technical procedures such as cisternal puncture, paracentesis, gastric intubation and the like. Often the internist is considered long on diagnosis and short on therapy. Books like this are, therefore, doubly welcome in their emphasis on treatment.

ULYSSES M. FRANK, M.D.

Diagnostic Standards and Classification of Tuberculosis. New York, 1961. National Tuberculosis Association. Pp. 56. (Price not stated)

This eleventh edition of *Diagnostic Standards and Classification of Tuberculosis,* published by the National Tuberculosis Association, is the standard guide to the diagnosis and treatment of tuberculosis. This is more than a revision; it is practically a new guide. The contents have been rearranged and altered considerably, in an attempt to bring it into conformity with present concepts.

The chapter on Classification has been revised and the "clinical status" now includes the term "Quiescent" which has been reinstated after an absence of ten years. It is used as an intermediate classification between "Active" and "Inactive" to describe the status of patients with bacteriologically negative residual cavitation.

Classifications are included for extra-pulmonary tuberculosis as well as pulmonary, and sections devoted to basic anatomic, pathologic and physiologic concepts, to the clinical course of tuberculosis, and to diagnostic methods, including roentgenography, have been expanded. A special section on bacteriology describes not only the various strains of mycobacterium tuberculosis but also the unclassified mycobacteria which sometimes cause disease resembling tuberculosis.

A new feature of value to doctors and medical record librarians is the inclusion of coding systems used in classifying both pulmonary and extra-pulmonary tuberculosis.

The 1961 *Diagnostic Standards* is indispensable to any hospital, sanatorium, chest specialist or physician in general practice who treats patients with tuberculosis.

IRVING OCHERET, M.D.

Oxytocin. By R. Caldeyro-Barcia and H. Heller: Proceedings of the 1959 Montevideo Symposium. New York, 1961, Pergamon Press. ($15.00)

This is an interesting and important reference work on the hormone which is used so widely in obstetrics. It is a well organized collection of papers and discussions from an international symposium. It covers all aspects of the use of oxytocin including physiology, pharmacology, clinical and experimental effects, and a comparison with related preparations. Oxytocic inhibitors and technics for determining amounts of circulating oxytocin are also covered. Papers presenting divergent opinions are presented, illustrating how conflicting views arise from different types of experimental approach to a single problem. The discussions are informative and add to the value of the formalized presentations.

Many of these summaries do not contain references to information useful to the clinician, as expressed in the paper. To dig out this material, reading of the whole volume is necessary.

Experimental procedures and technics are presented in detail, so that this volume is not a simple collection of didactic facts easily assimilated by the clinician. It does, however, give a comprehensive presentation of the status of oxytocin and includes extensive information valuable both to the researcher and to the practitioner.

After reading these comprehensive studies, this reviewer is more impressed than ever with the amount there is still to learn about the human uterus and the unknown factors involved in the processes of labor.

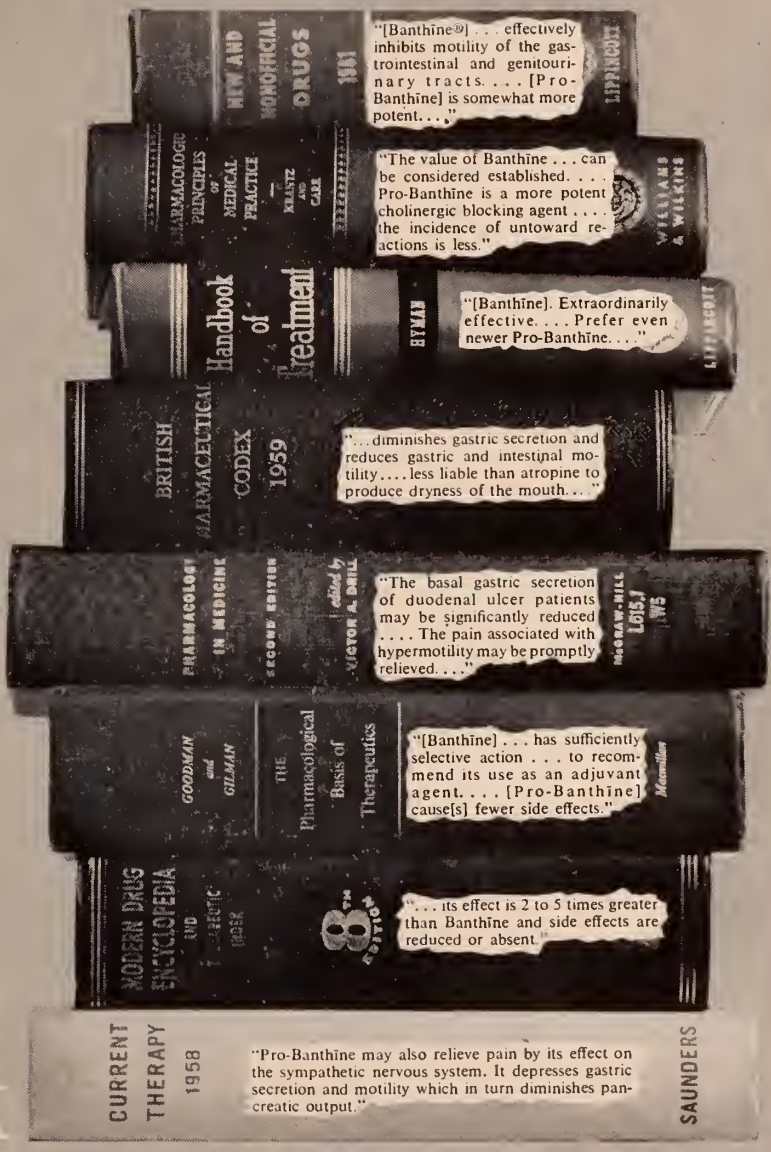
J. B. SKELTON, M.D.

Rehabilitation of a Child's Eyes. H. M. Katzin, M.D. and Geraldine Wilson, R.N. St. Louis. 1961, Mosby. Pp. 107. ($3.75)

This well-written little book represents a third edition of the original by the late Dr. Richard Scobee, whose untimely death cut short a most promising career. This text is prepared primarily for parents of children with strabismus. It aims at greater understanding between their ophthalmologist and themselves. It is written simply, with clear explanations and diagrams of some of the fundamental concepts of strabismus, hyperopia, myopia and orthoptics as well as muscle surgery. The book serves this purpose well although one may argue with the exact place of such a text in the parent-physician relationship. Certainly, it is no substitute for unhurried and patient discussion, a clear explanation by the physician of the diagnosis, treatment and prognosis in each individual. This volume may be of value to doctors who refer such patients to the ophthalmologist in order that they may have a clearer understanding of the situation.

The reviewer found most valuable to be these few sentences in explaining the role of the parent: "The best parents are those who understand and observe but say very little . . . Children will accept almost anything as a matter of course if it is presented to them that way. No attempt at verbal reassurance succeeds."

S. JEROME GREENFIELD, M.D.



by the book

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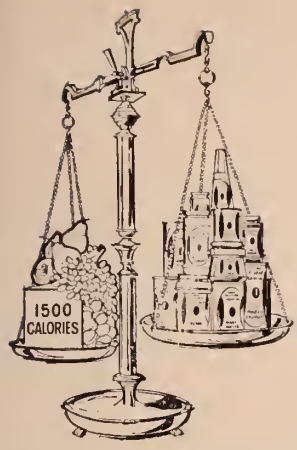
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Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
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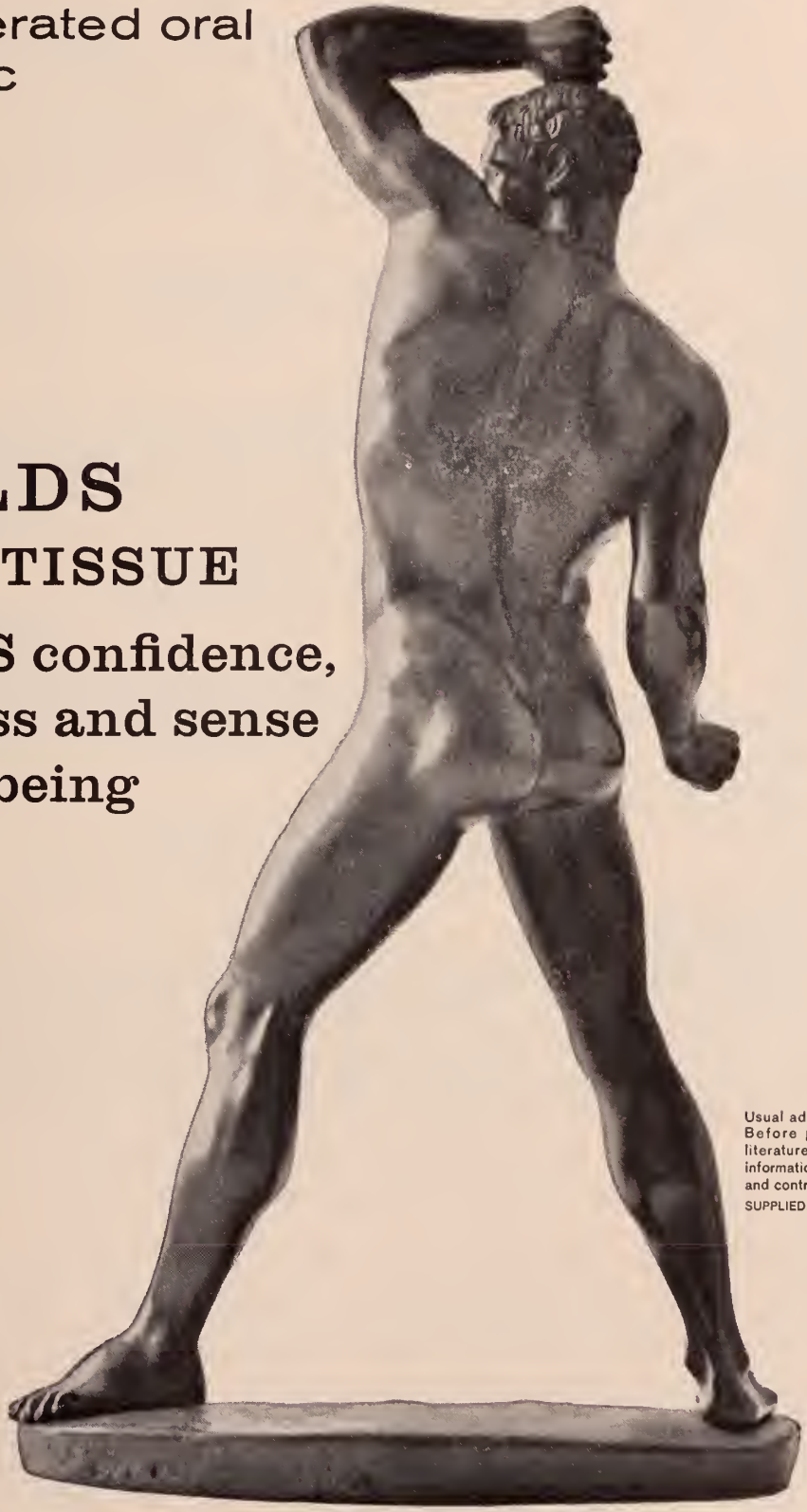
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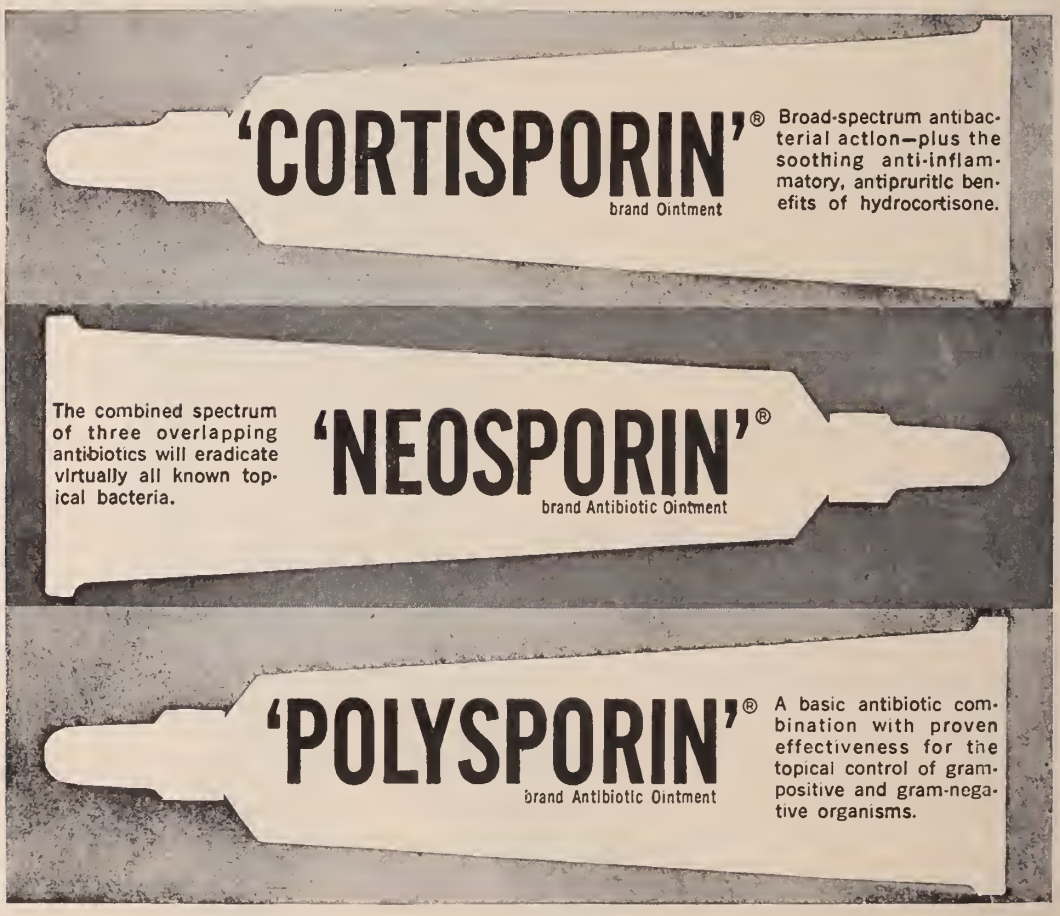
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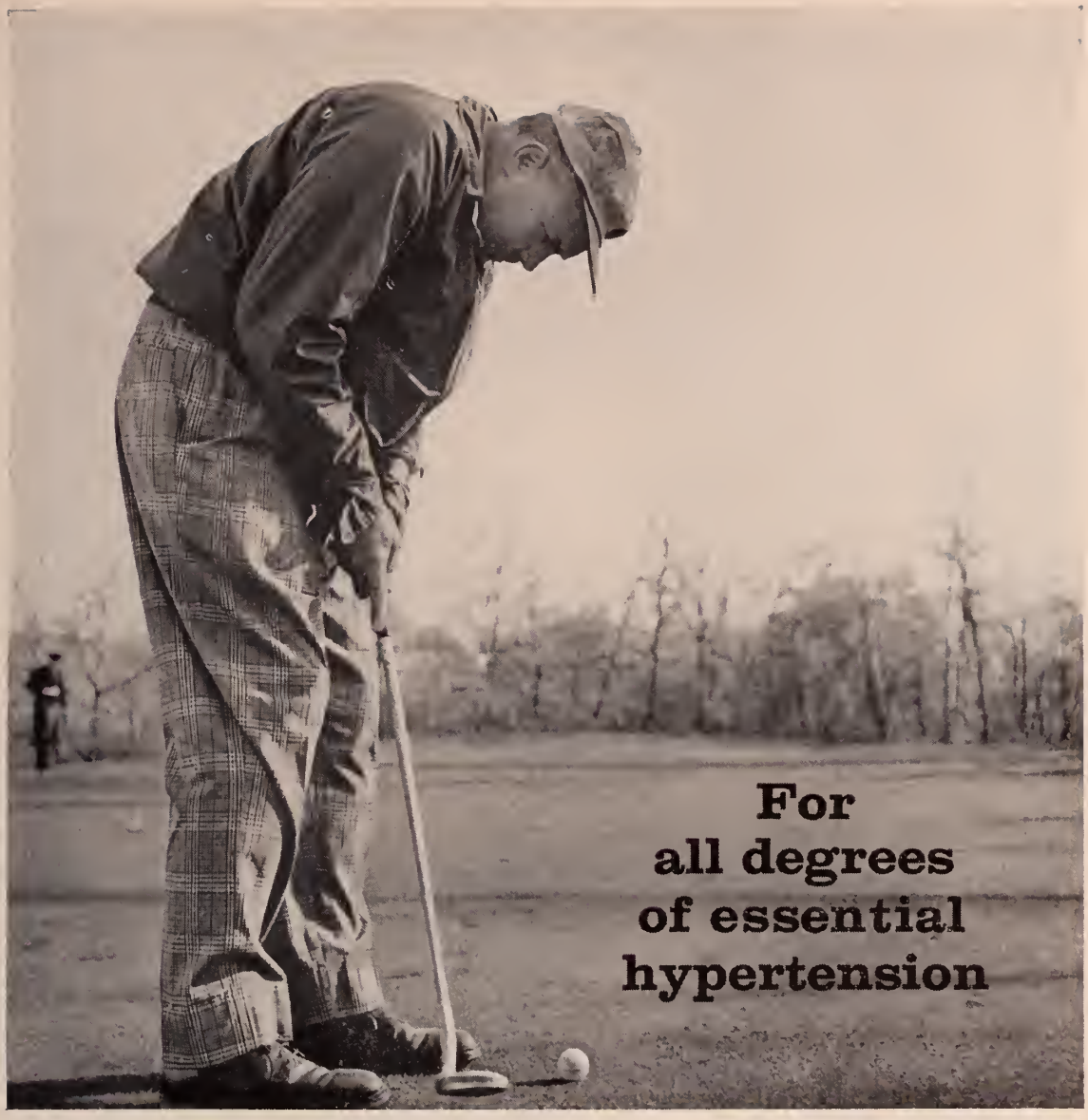
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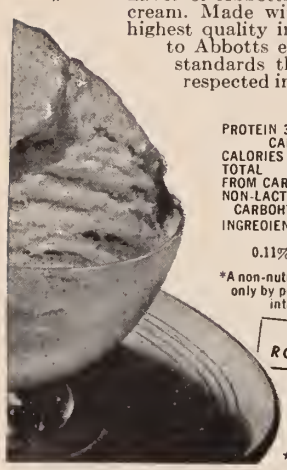
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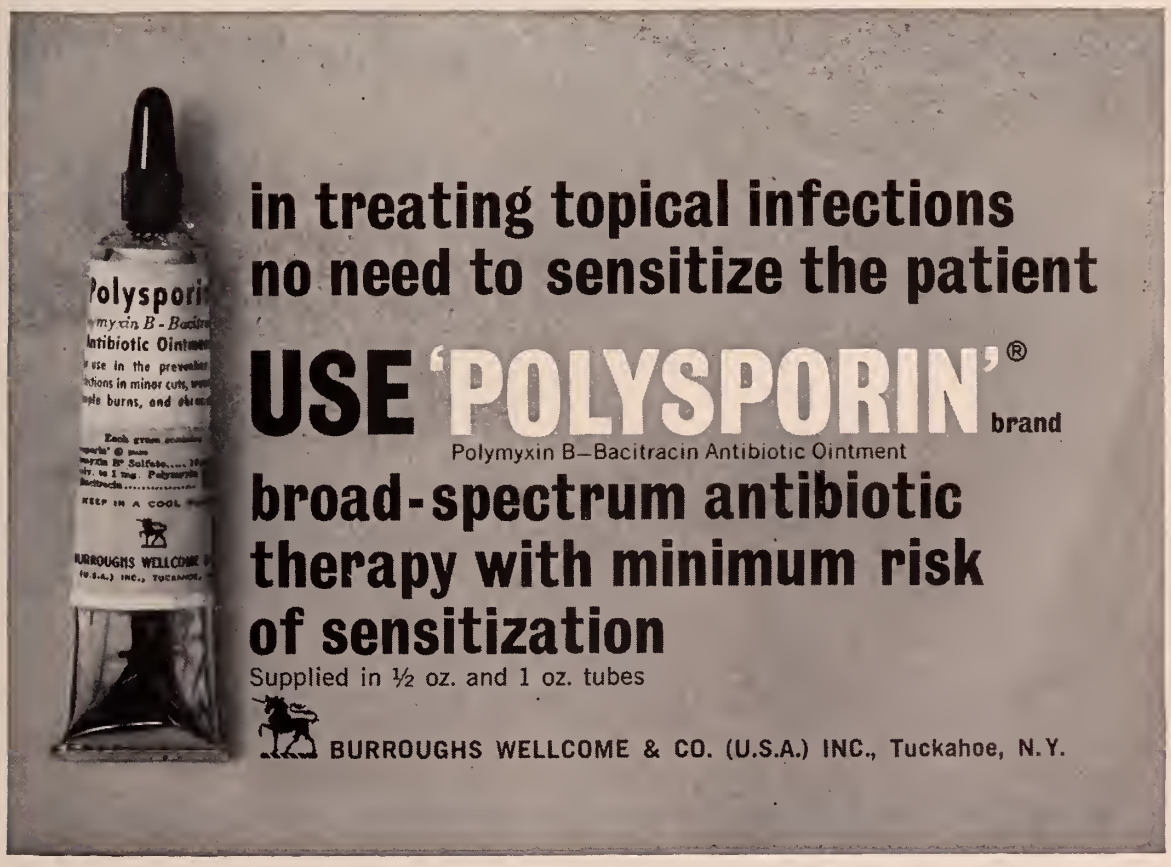
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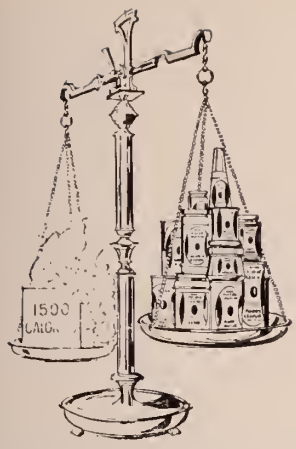
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	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



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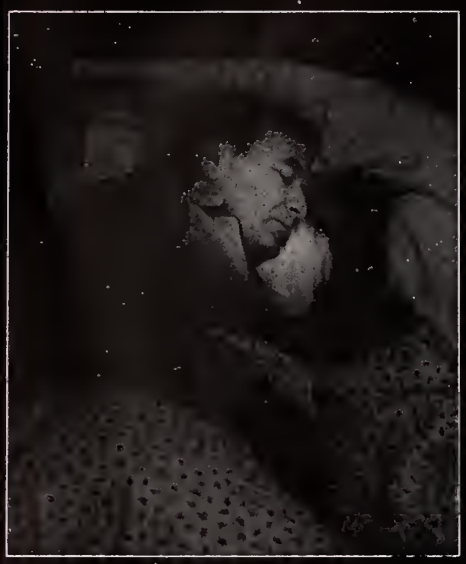
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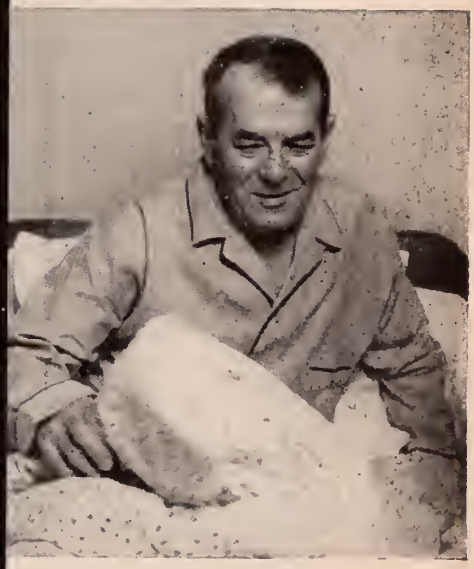


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(1) Simon, F. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 32-37, Jan. '61.

(2) Plotz, M.: "Modern Management of Obesity, J.A.M.A., 170:1513-1515 (July 25) 1959.

(3) Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med., 907-920, May '61.

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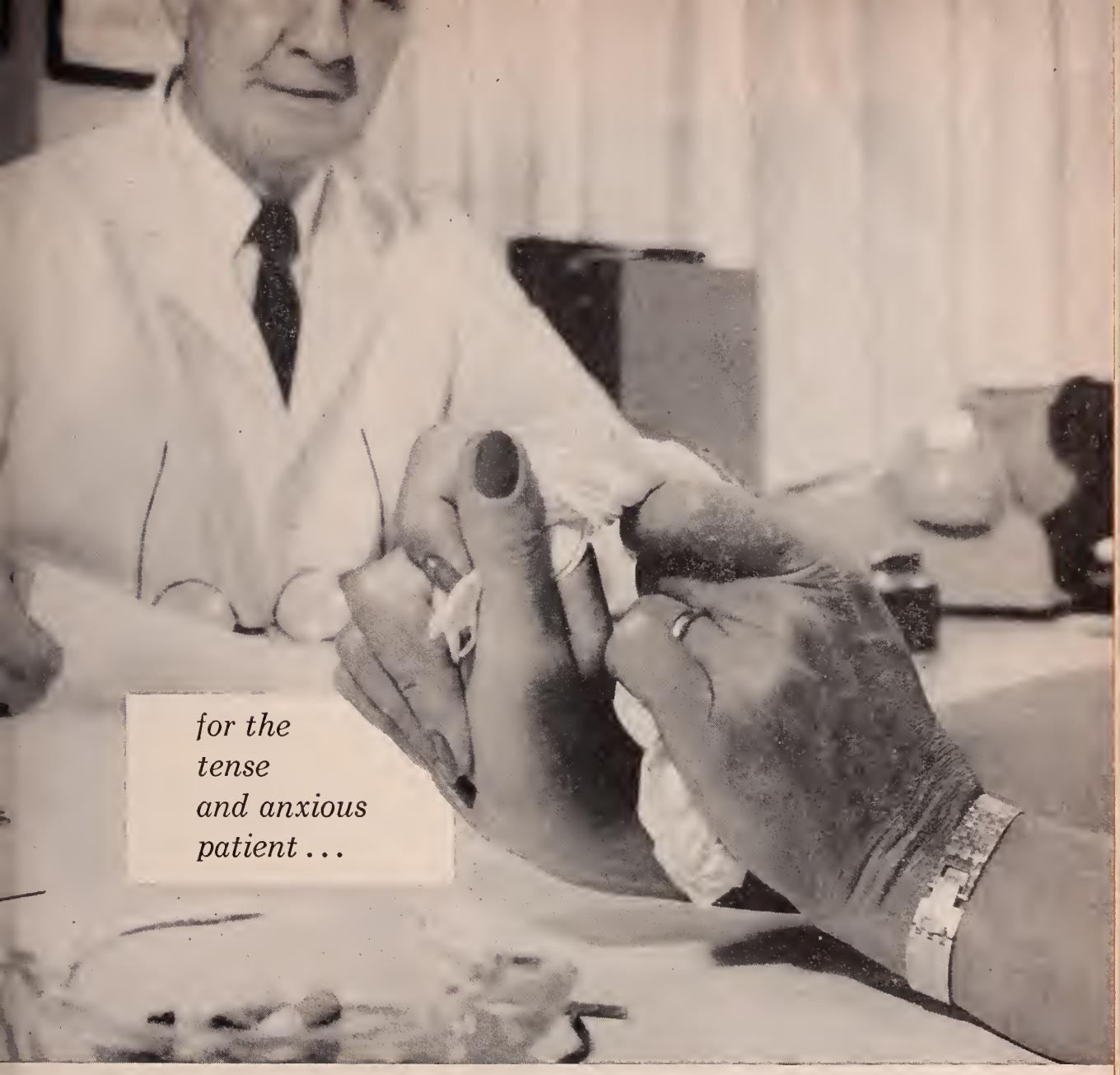
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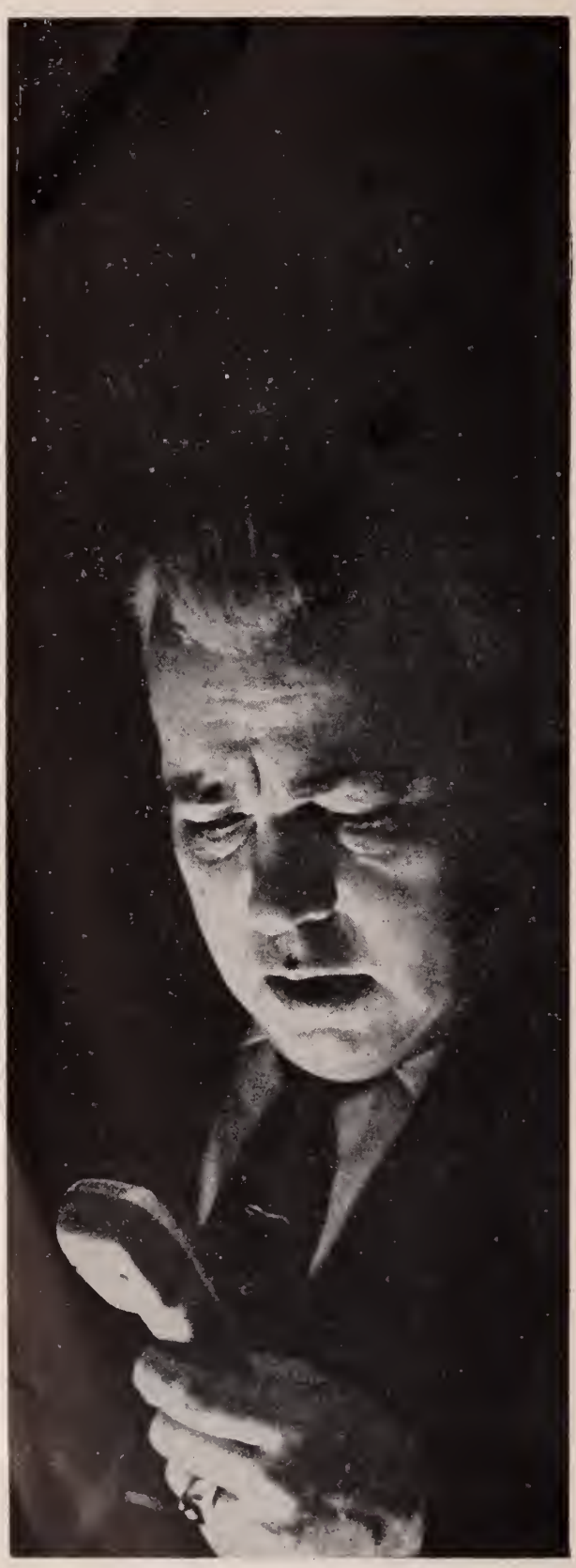
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1 Ford, R. A., and Blanchard, K Journal Lancet 78 185, 1958.

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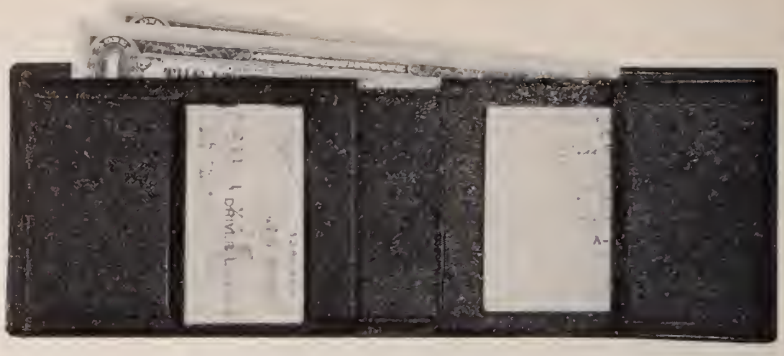
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One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.



BENEFICIAL RESULTS were obtained with **SARDO** in the bath in 122 of 135 patients (90%) with dry, itchy skin conditions, in most cases with beneficial effect "after the first bath." Dryness was allayed in all cases, and associated itching "either completely relieved or greatly improved." No irritation or sensitization was observed.

This new study corroborated others[2-4] showing that SARDO helps re-establish the normal physiologic lipid-aqueous skin balance.

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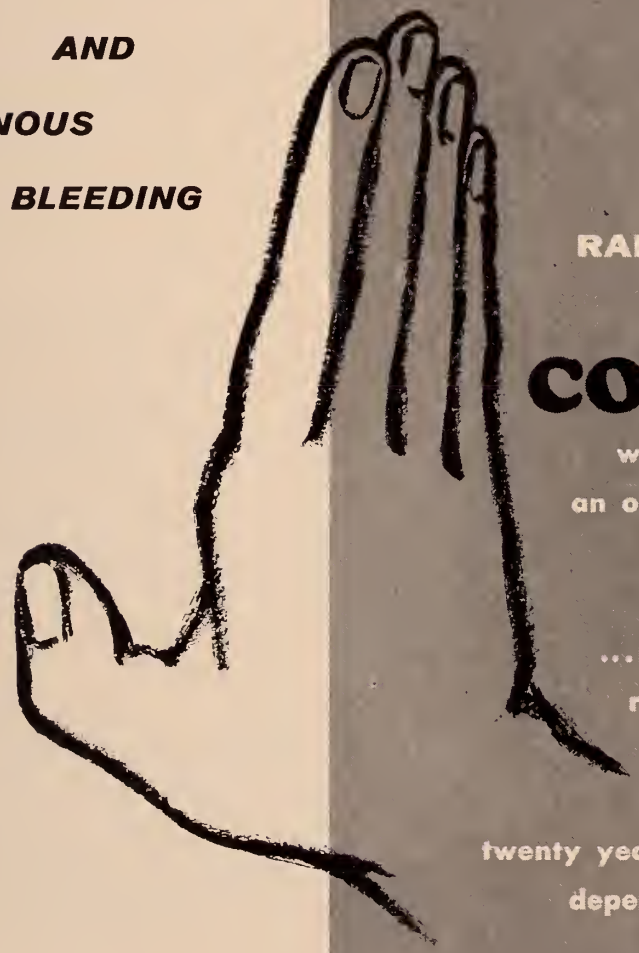
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3. Lubowe, I. I.: Western Med. 1:45, 1960.
4. Weissberg, G.: Clin. Med. 7:1161, 1960.

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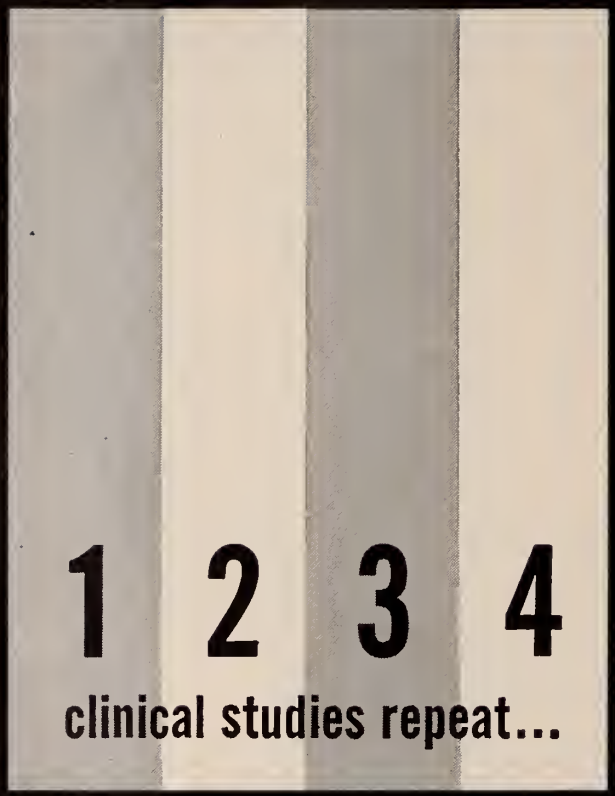
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CM-6709



ARLIDIN IMPROVES HEARING[1]
ARLIDIN IMPROVES HEARING[2]
ARLIDIN IMPROVES HEARING[3]
ARLIDIN IMPROVES HEARING[4]

1 "significant hearing improvement" occurred with Arlidin in 32 of 75 patients with recent onset hearing impairment due to labyrinthine artery ischemia.

Rubin, W. and Anderson, J. R.: Angiology 9:256, 1958.

3 Arlidin "appears to be one of the most satisfactory [vasodilators], having the advantages of minimal side effects, being well tolerated and possessing a sustained action" in improving circulation of the inner ear.

Seymour, J. C.: Laryngology & Otology 74:133, 1960.

Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution.
See PDR for packaging.

Protected by U.S. Patent Numbers: 2,661,372 and 2,661,373.

2

vascular insufficiency of the labyrinth is an important etiologic factor in sudden perceptive deafness... "vasodilators [Arlidin] are of considerable value."

Wilmot, T. J. and Seymour, J. C.: Lancet 1:098, 1960.

4

early cases of sudden perceptive deafness should be treated by immediate stellate block "supplemented by the most effective vasodilator drug [Arlidin]... energetic measures to retain blood supply to the inner ear are imperative."

Wilmot, T. J.: J. Laryngology & Otology 73:466, 1959.

impaired hearing tinnitus vertigo

when due to ischemia of the inner ear...

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brand of nylidrin hydrochloride N.N.D.

Clinical benefit in approximately 50% of cases of recent onset hearing loss treated with adequate vasodilator and other supportive therapy is also reported by Sheehy.

Sheehy, J. L.: Laryngoscope 70:885, 1960.

NOTE — before prescribing Arlidin the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects and contraindications, etc. Write for complete detailed literature.

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NTZ is more than a simple vasoconstrictor. It contains Neo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; Thenfadil® HCl 0.1% for potent topical antiallergic action; and Zephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas. NTZ is well tolerated and does not harm respiratory tissues.

NTZ Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

helps hay fever patients forget the "season"

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ulcer under repair

"What results can I expect in my ulcer patients?" Shown below is a tabulation of 795 ulcer patients, reported by 69 investigating physicians, in which glycopyrrolate was the anticholinergic employed. They represent a cross section of ulcer patients of all ages, both ambulatory and hospitalized, under various regimens, from all sections of the country.

Note the pattern of results. Robinul showed an "excellent" or "good" response in over 83% of patients, and Robinul-PH provided similar results in 81%.

As for side effects, these often troublesome extensions of anticholinergic action such as dry mouth, blurred vision, etc., were evaluated as "moderate-to-severe" in only 6.7% of a total of 1705 patients in preliminary investigative studies, 795 of whom are the ulcer cases tabulated here.

We invite you to try Robinul in your own practice. We believe you will find it one of the most effective agents you have ever used for the management of the ulcer patient.

Robinul® (formerly Robanul)
Each tablet contains glycopyrrolate, 1.0 mg.

Robinul®-PH (formerly Robanul-PH)
Each tablet contains glycopyrrolate, 1.0 mg.; and phenobarbital (¼ gr.), 16.2 mg.

Robinul® at work

Brand of glycopyrrolate, Robins

results with Robinul and Robinul-PH in 795 ulcer patients, from 69 clinical investigators*

DIAGNOSIS	ROBINUL					ROBINUL-PH				
	*No. Patients	Excellent	Good	Fair	Poor	*No. Patients	Excellent	Good	Fair	Poor
Marginal Ulcer	11	3	3	3	2	1	0	1	0	0
Pyloric Channel Ulcer	6	3	1	0	2	2	1	1	0	0
Pyloric Ulcer	4	2	1	1	0	1	1	0	0	0
Gastric Ulcer, bleeding	3	1	2	0	0					
Gastric Ulcer	48	31	11	1	5	12	5	7	0	0
Gastric Ulcer, penetrated	1	0	1	0	0	1	1	0	0	0
Gastric Ulcers, multiple	1	1	0	0	0					
Duodenal Ulcer	494	220	195	48	31	99	41	38	13	7
Duodenal Ulcer, bleeding	38	19	15	3	1	2	1	0	1	0
Duodenal Ulcer, obstruction	13	4	3	1	5					
Duodenal Ulcer, perforated	5	2	1	0	2	6	0	3	1	2
Gastric and Duodenal Ulcer	4	2	2	0	0					
Peptic Ulcer, unspecified	25	19	4	0	2	18	8	7	2	1
TOTALS	653	307	239	57	50	142	58	57	17	10
		83.6%					81.0%			

*Clinical reports on file, A. H. Robins Company, Inc.

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Richmond 20, Virginia

To the ONE New Jersey Doctor in FIVE

Who is NOT a BLUE SHIELD Participating Physician . . .

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Perhaps you have not recently acquainted yourself with the Plan's latest:

- Eligible Procedures
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Many liberalizations, broadening of coverage and upward revisions of benefits have taken place recently.

Now, more than ever before, participation in Blue Shield offers to the physicians of New Jersey advantages over and above assured payment of fair fees. It is the only instrument for putting adequate medical care within the financial reach of persons of modest income — including the elderly — through the voluntary system of medical practice.

Your inquiries regarding participation will be welcome.

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More than 6,600 Participating Physicians



Liquid asset

Now that we have added a new liquid-dosage form to our Panalba* family, you may prefer to begin treatment with Panalba KM* Drops when dealing with bacterial infections of unknown etiology in infants and children. From the outset, pending laboratory determinations, your treatment is broadened in antibacterial coverage because of the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most bacterial infections of unknown etiology, Panalba offers excellent chances for therapeutic success—and why it should be your antibiotic of *first* resort.

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Panmycin* (tetracycline) equivalent to tetracycline hydrochloride .... 125 mg.
Albamycin* (as novobiocin calcium) ..... 62.5 mg.
Potassium metaphosphate ... 100 mg.
Usual pediatric dosage:
½ teaspoonful per 7½ to 10 pounds of body weight per day, administered in two to four equally divided doses.
(Reminder advertisement. Please see package insert for detailed product information.)

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brand of sustained release capsules

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INDICATIONS AND DOSAGE: For the following indications, the recommended daily dosage is one or two 'Dexedrine' *Spansule* capsules, usually taken in the morning: control of appetite in weight reduction; depressive states; alcoholism. In narcolepsy, the recommended daily dosage is up to 50 mg. of 'Dexedrine' by 'Spansule' capsule on arising.

SIDE EFFECTS: Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

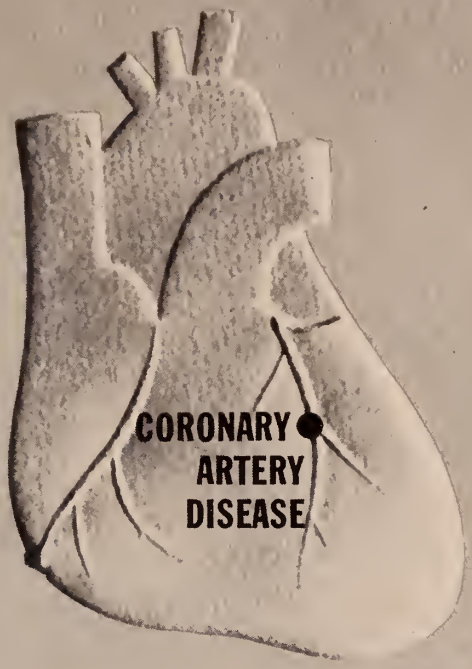
CAUTIONS: Should be used with caution in patients hypersensitive to sympathomimetic compounds; in cases of coronary or cardiovascular disease; and in the presence of severe hypertension.

CONTRAINDICATIONS: Hyperexcitability; agitated pre-psychotic states.

SUPPLIED: 5 mg., 10 mg. and 15 mg., in bottles of 30. (Each capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.)

Prescribing information adopted January 1961.

Smith Kline & French SK&F *Laboratories*



● "...now the leading cause of death in diabetic patients."[1]

Diseases of the cardiovascular-renal system account for about three-fourths of deaths among diabetic patients, with heart disease responsible for approximately one-half the total,[2,3] and coronary atherosclerosis the major cause of cardiac lesions.[1] While some feel that diabetics are predisposed, perhaps by heredity, to early onset of vascular disease, considered opinion is that vascular degeneration can be delayed or modified with "...careful and consistent control of diabetes from the time of diagnosis...."[4]

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for quantitative estimation

color-calibrated

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urine sugar

- continued, close control
- graphic *Analysis Record* encourages cooperation...reveals degree of control at a glance...helps patient maintain control

for "yes-or-no" enzymatic testing

new, improved

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10-second reading...longer strip for easier handling...new color chart and color barrier for test area...in glass for protection

Supplied: CLINITEST Urine-Sugar Analysis Set (with bottle of 36 tablets and 2 foil-wrapped tablets); refill boxes of 24 Sealed-in-Foil Reagent Tablets and bottles of 36 tablets. CLINISTIX Reagent Strips in bottles of 60.

References: (1) Root, H. F., and Bradley, R. F., in Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: The Treatment of Diabetes Mellitus, ed. 10, Philadelphia, Lea & Febiger, 1959, pp. 411, 437. (2) Joslin, E. P.; Root, H. F.; White, P., and Marble, A.: *ibid.*, pp. 188-189. (3) Marks, H. H., *et al.:* Diabetes 9:500, 1960. (4) Marble, A., in Summary of Conference on Diabetic Retinopathy, Survey Ophth. (Part 2) 6:611-612, 1961.

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For people "on the run," who skip or skimp on meals . . . for young folks with nutritional deficiencies . . . to supplement convalescent diets . . . as a replacement for solid foods when indicated . . . or to provide measured calorie-intake in weight control programs . . . please consider WALKER-GORDON 900. Made with Walker-Gordon Certified Milks. Each quart furnishes 58 gm. Protein, 130 gm. Carbohydrate, minimum daily requirements of vitamins and minerals, and only 17 gm. fat (900 calories). Write or phone for professional sample.

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HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

> Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days.* (*J.A.M.A. Vol. 172, No. 18, April 30, 1960.*)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. **USUAL DOSAGE: 1 TABLET Q.I.D.**

The muscle relaxant with an independent pain-relieving action

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(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey



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IN BRIEF The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

More detailed professional information available on request.

Boutonneuse fever is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

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For peptic ulcer gastric hyperacidity and gastritis...

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*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

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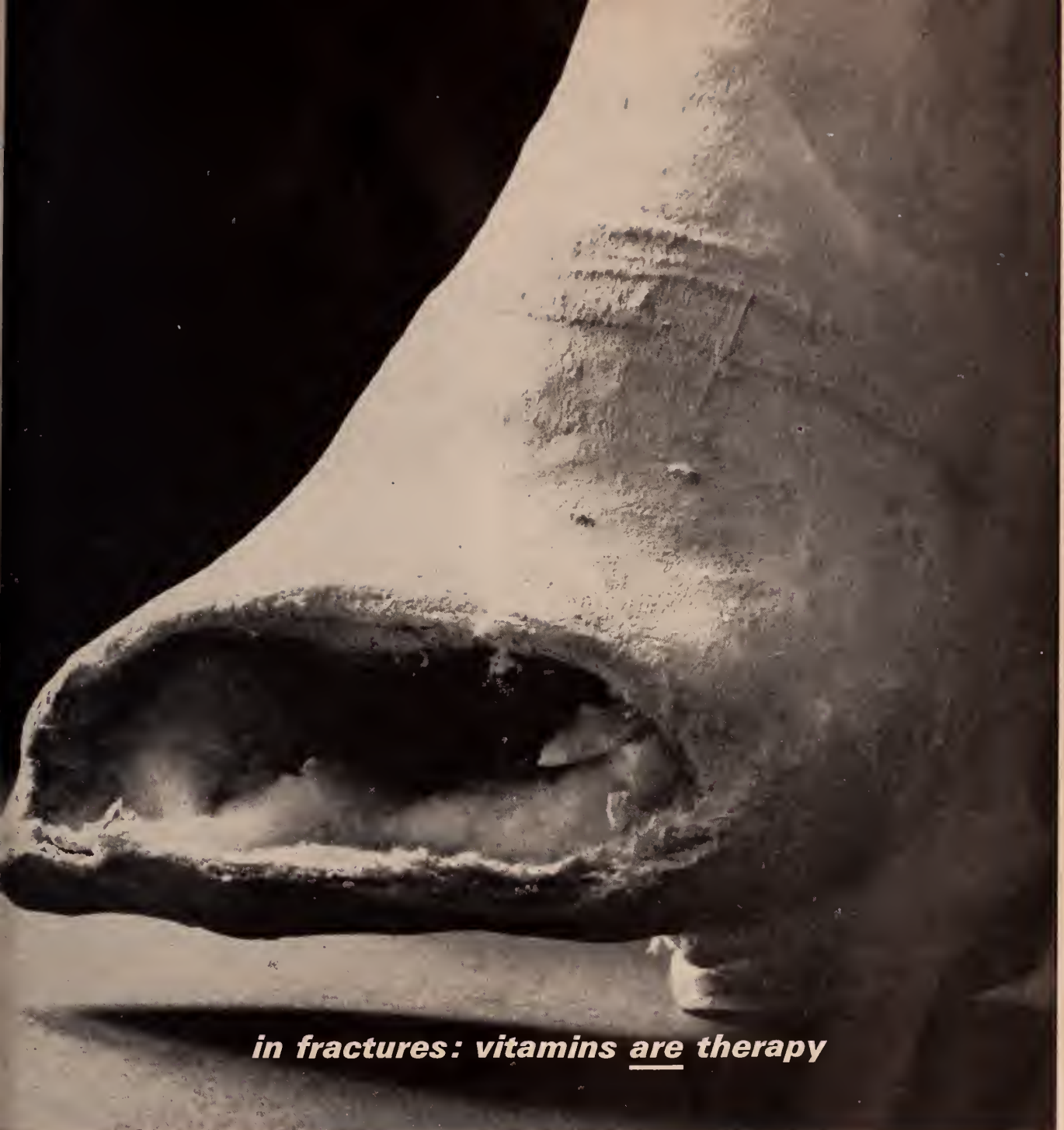
Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

Winthrop LABORATORIES New York 18, N. Y.



Few factors are more fundamental to tissue and bone healing than nutrition. Therapeutic allowances of B and C vitamins are important for rapid replenishment of vitamin reserves which may be depleted by the stress of fractures. Metabolic support with STRESSCAPS is a useful adjunct to an uneventful recovery. Supplied in decorative "reminder" jars of 30 and 100.

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Vitamin B_1 (Thiamine Mononitrate)	10 m
Vitamin B_2 (Riboflavin)	10 m
Niacinamide	100 m
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Vitamin B_6 (Pyridoxine HCl)	2 m
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Recommended intake: Adults, 1 capsule da or as directed by physician, for the treatm of vitamin deficiencies.

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Housework in a.m., shopping in p.m. (B.P. down, dizzy spells relieved)



Gardening is enjoyable again (edema gone, spirits up)

often the only therapy needed to control blood pressure and relieve symptoms in mild or moderate cases*

NAQUA potentiates other antihypertensives when used adjunctively.... Side effects are minimal.... Economically priced.

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For complete details, consult latest Schering literature available from your Schering Representative or Medical Services Department, Schering Corporation, Bloomfield, New Jersey.

*Schaefer, L. E.: Clin. Med. 8:1343, 1961.

S-963



. . . even though surrounded by allergens. Co-Pyronil® provides smooth, continuous control of allergic symptoms—relief in minutes for hours, with virtually no side-effects. And there is a dosage form for every allergic patient.

Pulvules® · Suspension · Pediatric Pulvules

Co-Pyronil®

(pyrrobutamine compound, Lilly)

Each Pulvule contains Pyronil® (pyrrobutamine, Lilly), 15 mg.; Histadyl® (methapyrilene hydrochloride, Lilly), 25 mg.; and Clopane® Hydrochloride (cyclopentamine hydrochloride, Lilly), 12.5 mg. Each pediatric Pulvule or 5-cc. teaspoonful of the suspension contains half of the above quantities. This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana.

Lilly

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Who Shall Measure Drug Effectiveness?

Proposed federal legislation would permit the Food and Drug Administration to ban a new drug if some clinicians found it ineffective. Thus, practically unanimous agreement would be required. It is argued that if the experts are not in agreement, the drug should not be marketed.

Are experts really that reliable? Let's look at the record. For centuries men dreamed of flying. But experts were skeptical. Baron Gottfried von Leibnitz, the German philosopher, doubted that man would ever fly: "Here God has put a bar across man's path." The French astronomer Joseph Lalande demonstrated that flight was a scientific impossibility.

After George Stephenson's locomotives reached the speed of 30 miles an hour, the Munich College of Physicians issued a warning against railway travel. Trees and houses flashing past the eyes would damage vision; the dizzy speed would bring on vertigo. In England, it was predicted that traveling at 30 miles an hour would cause insanity.

When Samuel Clegg proposed to light the streets of London with gas, scientists "proved" that lighting a jet would cause all the gas in the tank to explode, reducing the city to ruins. And experts also proved that Alexander Graham Bell's proposed telephone was, in their words, a "triumph of folly."

In scientific matters generally there is always a body of conservative opinion skeptical of *all* new proposals. In no branch of knowledge has innovation had to battle conservative opinion more often than in medicine. Nearly every great discovery has made its way despite official skepticism. Biology is a complex science, in which well-qualified experts may evaluate facts in very different ways.

Jenner's vaccination for smallpox, Semmelweis' contribution to the prevention of puerperal fever, and Findlay's discovery of the role of the mosquito in transmitting yellow fever followed long trial-and-error experiments during which many authorities honestly believed the innovator to be following a blind alley. Cod liver oil was rejected as worthless by an authoritative medical body as late at 1919.

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The first sulfa drug introduced in the United States was judged ineffective by an outstanding authority. The same authority dismissed early English reports on penicillin as incredible. When he was offered a culture of penicillin for testing, he actually poured it down the sink.

As these instances demonstrate, the preliminary opinion of leaders in the field is often different from the final judgment of the medical profession as a whole. This seems to be overlooked in the Kefauver-Celler Bill (S. 1552, H.R. 6245) and the Harris Bill (H.R. 11581) which would give the Secretary of Health, Education, and Welfare unlimited power to pass on the effectiveness of new drugs. Under these bills, the Food and Drug Administration could keep off the market a drug found effective by some clinicians, but not by others.

It is proper that the Food and Drug Administration hold up a new medicine if there is doubt as to its safety. On the other hand, if the FDA refuses to pass a new drug until the whole medical profession agrees on its effectiveness, many a valuable medicine (like the sample of penicillin) will go down the drain.

The criterion as to effectiveness should be that the manufacturer of a new drug must offer substantial evidence (but not necessarily unanimous opinion) to support his claims. When a reasonable number of clinicians have conducted tests which show the drug to have the claimed effects (even though other clinicians disagree) the FDA should permit the drug to be marketed.

Dr. Hugh H. Hussey, Jr., appearing before the Kefauver Subcommittee as spokesman for the American Medical Association, underscored this when he said: "A drug which is, on the average, less efficacious than another, must still be available to every physician, since it may be completely efficacious in treating the medical problems of one of his patients. We do not practice medicine on the average—we seek to solve or alleviate the problems of each and every patient."

In the final analysis, the only sound criterion of the ultimate value of a new drug is the consensus of medical opinion arrived at over a reasonable time and under the conditions of actual practice.

A government bureau can prevent this judgment, and thus postpone indefinitely vital contributions to the health of our nation.

The Dismal Utopias of Science Fiction

It used to be that the "world of the future" was decribed as a pretty and prosperous place where everybody was happy. Up to about 75 years ago, whenever any author described the world of the future, he visualized a Utopia which was the title coined for this by Thomas More.[1] Ideal worlds were conceived by many older authors: Plato's "Republic"; Bacon's "New Atlantis"; More's "Utopia"; Butler's "Erewhon"[2] and the world in Bellamy's "Looking Backwards," published in 1887.

At the turn of the century all this changed. The future worlds dreamed up by twentieth century authors were pretty wretched places. You can't blame this on the atomic bomb, since the paradises became putrid long before the A-bomb was heard of. For instance, in 1923, Carl Capek wrote the play "R.U.R."[3] The "Brave New World" of Aldous Huxley was published in 1932. In George Orwell's "Nineteen Eighty Four," (1949) the A-bomb was known but played no part in making that world so nasty.

So it was not the bomb which took the joy out of Utopia. What was it? It was the loss of faith in the perfectability of man. To children, the golden age is tomorrow—when they will grow up to do wonderful things. To the old, the golden age was a generation ago when things were better—"the good old days." When man turned into the twentieth century, our childhood came to an end. The golden world receded.

There used to be three pillars of faith on which was established the hope of a happy future. These pillars were: (1) That the earth was God's favorite planet and the center of His universe; (2) That man, made in God's image, was God's favorite being; and (3) That he had a soul and a mind logical enough to triumph over the demands of a brute body.

These props were knocked out one by one in the twentieth century or even earlier. By the mid-nineteenth century it was pretty well accepted that the man's residence was not the center of the universe. Then Darwin and his popularizers suggested that man was not separately created by God. And finally, modern psychiatry cast grave doubts on the power of reason and logic to overcome the compelling drives of biologically rooted instincts. So, one-two-three—the pillars of faith came tumbling down!

These three faiths now seem quaint and outmoded. Yet with their loss came, apparently, a loss of hope in the perfectability of man and a feeling that the world of the future will be a dismal one.

Well, once in history, an ark took survivors from an earthly holocaust. And if you are an agnostic and don't believe this parable, then take comfort in the thought that there always has to be a first time.

1. The *Man for All Seasons* now on Broadway.
2. Nowhere—spelled backwards (almost).
3. Where the word *robot* (Czech for slave) was first used.

Patient Participation in Research

Back in 1871, a New York appellate court held (*Carpenter v. Blake*) that "any deviation from the established mode of practice is sufficient to charge the physician or surgeon with negligence. This rule protects the community against reckless experiments, and admits the adoption of new treatments only after their benefits have been demonstrated."

This, at once, raises the question: until the benefit of the new treatment can be demonstrated, it is a deviation from the established practice. Thus, any advance in medicine or surgery is at the risk of the doctor. There is no sharp line between ordinary practice and clinical research. The first time a new drug is tried on a human being, the first time a new operative procedure is attempted, the activity is research. After the drug has been listed in several editions of a pharmacology text, and after the procedure is routinely taught to surgical residents, it is "established" and its use is practice, not research. But how about the period between? At some point it becomes routine rather than research.

Courts are reluctant to give the researcher any more latitude than the practitioner. From the legal viewpoint, the research is still a matter of a doctor's trying to help a patient, and the doctor experiments at his (the physician's) peril. The *Carpenter* decision (cited above) remains unreversed after 91 years; and in law, unlike medicine, the older an unreversed decision, the more binding it is.

No one has developed any ground rules for ethical or legal human experimentation. The prime rule, everyone says, is this: if the patient is to be a guinea pig he ought to know all about it and consent to it. This, however, runs into trouble when the experimenter wants to use the double blind technic. Suppose he says to the patient: "This pink medicine I'm giving you is a placebo, and I want to see if it works as well as this new drug." This destroys one of the prime elements of the double-blind technic.

The researcher's monetary awards are below those of the practitioner. His motivation certainly is an honorable one. Either he is driven by a genuine compassion for people and a desire to help them; or he just has an itch to know. But surely in this age we should not say to the researcher: you practice your calling at your peril. If you want to help humanity, you must do so at your own risk.

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Coma Due to a Combination of Barbiturates, Scopolamine and Dihydroergotamine

Here a woman swallowed 25 times the hypnotic dose of a proprietary barbiturate combination. Her recovery is attributed to the vigorous measures here described.

This is the report of a young woman who was in coma for five days following the ingestion of 99 tablets of a product which contains three barbiturates, scopolamine and dihydroergotamine. It is being reported because of the long duration of coma, the large quantity of barbiturates ingested with survival, and as an aid to the management of similar cases. Although the toxicity of each ingredient is fairly well-known, very little has been published concerning coma following large doses of this particular combination formulation.

A 20-year old single woman was admitted to a hospital in coma at 2 p.m. She was last seen awake and in apparent good health at 9:30 p.m. on the previous evening. A bottle which had contained 100 tablets of Plexonal® was found in her room. When the patient subsequently came out of coma, she stated that she had taken one tablet two days earlier to "test its efficacy;" and having then taken the remaining 99 tablets the following evening. She had been under psychiatric treatment for a depressive reaction and schizoid personality.

She was a well developed and well nourished woman in coma. The ventricular rate was 100 per minute and regular, the blood pressure 108/80, the respiratory rate 26, and the rectal temperature 97.8 degrees. The pupils were wide and reacted very slowly to light. There was no corneal reflex. The lungs were clear and no murmurs were heard. The liver and spleen were not enlarged. The digits were warm and there was mild nailbed cyanosis. Pedal pulses were weak. She had bilateral ankle clonus. No other deep tendon reflexes were present. The extremities were spastic. There were no Babinski or Hoffman signs.

During the evening of the first hospital day, the nailbed cyanosis increased, the respiration rate increased to 40, the pulse rate to 112, and the temperature rose to 103 degrees F. Biceps reflexes became 2-plus. She had tonic convulsions on stimuli such as venipuncture or aspiration through the airway.

Initial therapy (in addition to one Gram of caffeine-sodium benzoate administered prior to admission) included insertion of an airway and an indwelling urinary catheter; nasal oxygen; and intravenous 5 per cent dextrose in water with two or three grains of papaverine added to each liter. As respirations became more rapid and ineffectual, a positive pressure mask and then an Emerson respirator were used. Small doses of sodium amobarbital† were given intravenously to control convulsions. Vital signs were followed every 15 to 30 minutes, the patient turned frequently, and the airway suctioned as needed.

During the early hours of the second hospital day ethamivan (Emivan®) was used, one Gram in 250 cubic centimeters of normal saline intravenously at 10 milligrams per minute. There was no immediate noticeable effect upon the clinical condition. Tetracycline was administered, as was five per cent carbon dioxide in 95 per cent oxygen with the respirators. Rectal salicylates were given for fever.

Eight hours after the ethamivan, the respiration rate was 28 per minute and respirations were effective out of the respirator. Blood pressure was 100/80, and the temperature had dropped below 101 degrees F.. A few scattered rales were audible.

†We used the Lilly brand, trade named Amytal®.

The pupils were wide and unreactive to light. Knee and ankle reflexes were 2-plus. There was still moderate nailbed cyanosis and the fingers were cold.

At the end of the second day the airway was becoming more frequently obstructed with hard mucus despite the use of surface active agents. Tracheostomy was done. A polyethylene catheter was placed in the right greater saphenous vein for administering fluids.

The next morning the respiration rate was 32 and there was minimal cyanosis. The pupils were dilated and demonstrated hippus. Triceps jerks were elicitable. During the evening of the third hospital day the nailbeds were pink. Other findings were unchanged.

Edema and erythema of the right leg were noted during the fourth day. The temperature was 101 degrees F., respirations 32 per minute, and pulse rate 108. The pupils were wider. The cut-down was discontinued and the patient heparinized to treat the phlebitis.

On the fourth hospital day, the left arm moved in response to painful stimuli, and the eyes wandered laterally. The pupils were smaller in diameter and reacted to light. One Gram of caffeine-sodium benzoate was given intramuscularly every four hours.

On the fifth hospital day, there was spontaneous movement of all extremities and the eyes opened in response to noise. The leg phlebitis was subsiding. The serum potassium had fallen to 3.2 milliequivalents per liter; then 40 milliequivalents of potassium chloride were given in the intravenous fluids for two days. She reacted fully at 11 p.m. on the fifth hospital day, after a total period of coma of five days.

On the sixth day, she was fully reacted and talking with echolalia and scanning of speech. Oral fluids were tolerated. All medications were stopped, including heparin. There had been transient gross hematuria during the previous night.

On the seventh day there were no neurologic abnormalities. The tracheostomy tube was removed, and the patient started on erythromycin for bronchopneumonia. Bethanechol* was used because of inability to void. She continued to gain strength and was transferred to a psychiatric hospital on June 5. The lung fields were clear and there were no signs of phlebitis. Oral iron therapy had been started for an anemia which developed.

There has been only one other report[1] concerning the ingestion of a large amount of this particular combination of barbiturates, scopolamine and dihydroergotamine. In that case, a woman swallowed 40 tablets and was found 24 hours later in a deep sleep. She apparently responded to stimuli but asked that she be left to sleep. After 32 hours, her blood pressure, respiration and pulse rate were normal. Forty-eight hours after ingestion she was able to get up and for another day suffered from vertigo. She recovered fully from this episode.

The three barbiturates in the compound ingested are sodium diethylbarbiturate (barbital—45 milligrams per tablet) and sodium phenylethylbarbiturate (phenobarbital—15 milligrams per tablet), both of which are long-acting and excreted mainly by the kidney, and sodium isobutylallylbarbiturate (Sandoptal®—25 milligrams per tablet), which has an action of intermediate duration and is mainly degraded by the liver. The clinical picture and management of coma due to barbiturates are well-known.

The compound in question also contains scopolamine hydrobromide (0.08 milligrams per tablet), which inhibits effector organs innervated by post-ganglionic cholinergic nerves. Its actions and toxicity are similar to those of atropine, except that depressant actions are predominant in scopolamine toxicity. Marked toxic side effects may be noted with dosages over 5.0 milligrams, and coma with dosages over 10.0 milligrams. Blood pressure falls, respirations become inadequate and death due to respiratory failure occurs after a period of paralysis and coma.

The fifth ingredient of the compound is dihydroergotamine methanesulfonate (DHE 45—0.16 milligrams per tablet). In general, the adrenergic blockade caused by dihydrogenated alkaloids of ergot is stronger than that of the parent alkaloid, and the vasoconstriction is weaker. Dihydroergotamine is much less toxic than ergotamine. Vomiting, diarrhea, thirst, tingling, itching, coldness of skin, rapid and weak pulse, confusion and unconsciousness may occur with toxic amounts.

Thus, each of the individual ingredients ingested, if taken in sufficient quantity, may lead to coma. For barbiturates, it is estimated that 20, or even 15, times the hypnotic does may lead to death. Our patient ingested at least 25 times the hypnotic dose, to a total of 8.415 Grams of barbiturates; she survived. The ingested dose of scopolamine hydrobromide totalled 8 milligrams, which is in the range capable of producing marked toxic effects.

*We used the Merck brand, trade named Urecholine®.

1. Merdez, L.: *Medicina*, 35:364 (February 1951).

MANAGEMENT

THE management and prognosis of coma due to this formulation have not been described previously. The clinical picture will vary from one case to another because of variable responses to any one ingredient, and because of the variable relative contribution to the overall picture of the various ingredients. It is necessary to treat each patient with regard to his own manifestations. General measures, attended to meticulously, will probably be adequate. An airway must be maintained; respirations must be helped if ineffective; shock must be treated; hyperthermia and infection must be combatted; fluids and electrolytes must be kept in balance; and nursing care must be given to indwelling catheters and tubes, the skin, the mouth, and the bodily position. Peritoneal dialysis or an artificial kidney may be resorted to if the situation appears critical or if the patient does not respond to the other measures. Analeptics should not be used too strenuously, in view of the convulsions demonstrated by this patient without analeptics. Gastric lavage should be tried if the patient is seen soon after ingestion. Respiratory stimulants, such as ethamivan, should be used in adequate dosage if spontaneous or artificial respirations are inadequate.

SUMMARY

A 20-year old woman ingested 99 tablets of a proprietary barbiturate and was in coma for five days. The course was complicated by convulsions, airway obstruction, phlebitis, bronchopneumonia, anemia, hypokalemia, and hematuria due to anticoagulants. There were no abnormal physical residuals. She was treated vigorously and effectively.

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Operative Deaths in Children

Stanley Brown and his co-workers* report on "errors" which resulted in operative deaths in infants and children in a hospital in New York during the 10-year period between 1947 and 1957. Since that time there has been a dramatic decrease in operative deaths. This improvement has resulted from careful review of all available data relating to operative deaths on the pediatric and surgical services. The 21 surgical deaths reviewed occurred among 4,090 infants and children operated on. Although a 0.5 per cent surgical mortality rate is favorable when compared with rates in other reports, the authors feel that 19 of the 21 patients might have survived had they received optimal care. Pediatric surgery demands special care, special skills, devoted interest, and constant medical and nursing attention. The surgical treatment of infants and children also demands a thorough knowledge of their physiology. There exists a tendency to assign the operative death of an infant or child to his small size, his failure to fight back, or his inability to "take the anesthesia well." Such unscientific classifications afford no knowledge from which lessons may be learned and future errors prevented. When honestly analyzed an operative death brings home the significance of fundamental precepts with a force that an "excused" fatality can never achieve. The surgeon who undertakes to operate upon an infant or child should bear in mind the admonition of Potts: "In the surgery of infants and children we are gambling not for a five-year cure, but for a 65-year survival."

*Surgery, Gynecology & Obstetrics, 114:137 (February 1962).

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Long-Term Use of Rauwolfia in Primary Hypertension

Observations on Patients Treated for Periods Up to Eight Years

Although he cites only 33 cases, Dr. Ruggieri offers one of the longest term studies of rauwolfia ever reported. Clinical results were classed as "excellent" in two-thirds of the cases. In spite of prolonged administration, untoward effects were almost entirely absent.

Primary (essential) hypertension has been described[1] as a chronic complex disorder of unknown origin characterized by abnormally high diastolic blood pressure in the absence of other manifestations of primary pathologic process. Treatment cannot be directed at removing the cause (since it is unknown). Instead, therapy tries to prevent the development of vascular changes and other complications associated with abnormally high levels of arterial pressure which could precipitate death. The aim is to reduce the blood pressure to normal or near normal levels and to maintain those levels. Many drugs will lower blood pressure. Their clinical value depends not only upon their hypotensive effect but also on their continued effectiveness and safety in use for many months or years.

Rauwolfia serpentina was introduced to American physicians as an antihypertensive drug in 1952. Since that time, innumerable reports have appeared. Among these reports, however, only a few[3 to 8] have been concerned with the determining factor of the usefulness of the drug: the effects of long-term use.

My own clinical experience with rauwolfia began in 1952. Since then I have been able to follow patients who have been on the drug for as long as 5, 6 or 7 years; one patient has been followed continuously for the full 8 years. Observations from this extended experience confirm and supplement the findings of others[3,4,5] that, over a period of years, rauwolfia maintains satisfactory control of blood pressure in hypertensive patients without toxic effect or even significant unpleasant reactions.

Methods and Materials

Of the 33 patients in the survey, 21 were women between the ages of 52 and 75 years; and 12 were men, aged 37 to 84. All but three were at least 50 years old; and 16 of these patients were at least 60 years old. All had arterial hypertension, with pretreatment blood pressure readings varying from 160 to 240, systolic, and from 90 to 150, diastolic. In most instances, the diagnosis was "essential" hypertension; in eight patients, heart disease was a complicating factor. One had a history of past myocardial infarction; a number exhibited evidence of coronary insufficiency and other cardiac impairment; two of the 8 were in congestive failure when first seen. One of the 33 patients had a history of a previous cerebral vascular accident.

Initial pretreatment examination included urinalysis and determinations of body weight, pulse rate and blood pressure levels. When indicated, the examination also included an electrocardiogram and chest x-ray. During the early months of treatment, patients were examined once each month. As treatment pro-

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Margate City

Acute Otitis Externa

Etiology, Diagnosis and Management

A practical four-step procedure for acute external otitis has proved effective in keeping Atlantic City residents, lifeguards or vacationers, in the water.

A few years ago acute infections of the ear were endemic only at bathing beach summer resorts. Now, with the increasing popularity of public and home swimming pools, these conditions occur with increasing frequency in inland sections. It seemed desirable, therefore, to develop a specific course of therapy for these infections that can be applied by the general practitioner as well as by the otologist.

Our practice is in a large seashore resort. Our patients are vacationing visitors living in hotels and motels, many with swimming pools. Not all of them are operated with meticulous hygienic care. Our practice also includes permanent residents, many of whom are school children or members of swimming clubs; all swim daily in the comparatively clean surf or in the less clean back bays from early spring until late fall; and some are young, vigorous, athletic lifeguards.

Care of the "beach patrol" group made necessary the development of a therapeutic procedure for external ear infections that would minimize time loss and keep the patient on a kind of duty which included daily frequent immersions. Such a routine to be described here, has been used successfully in more than 150 patients in the past few years, enabling lifeguards to carry on their duties, native adults and children to continue their aquatic pleasures, and visitors to resume enjoyment of their vacations.

TERMINOLOGY

The number of names applied to the acute inflammation of the external auditory canal almost equals the number of remedies proposed for their relief. This terminologic and therapeutic multiplicity is not surprising since the skin lining the canal is subject to all the diseases of the body integument; and it responds to the same therapy with only those differences attributable to its inaccessibility.

The formal term is "acute otitis externa." This is often conveniently shortened among otologists to 'acute externus.' These inflammations are also named, in the voluminous literature, according to their supposed primary or predominating etiologic or epidemiologic factors—acute, bacillary, fungal or viral external otitis. When the cause is thought to be bacillary the inflammation is named from the organism: pseudomonas, colon, diphtheroid, streptococcal, pneumococcal, (and so on) otitis. When fungi [11] are thought to predominate, the term is otomycosis.[16] Sometimes the offending fungus is named—aural aspergillosis, moniliasis, actinomycosis and the like.[24] More frequently used, however, are common names like swimmer's ear, beach ear, swimming pool ear, tank ear, stink ear, hot weather ear, tropical ear, jungle rot, adobe ear, mildew ear, Panama ear, Hong Kong ear or Singapore ear.[15]

ANATOMY

The external auditory canal is a narrow, tubular, roughly S-shaped cul-de-sac lined with profusely vascularized and well innervated skin and ending at the membrana tympani which is also covered with skin. Cartilage underlies the skin of the outer half, and bone that of the inner half, of the canal. The skin of the outer, cartilaginous half contains hair follicles and sebaceous and ceruminous (modified sweat) glands. That of the inner, bony half has no hair or glands and is closely attached to the periosteum, making even the least inflammatory swelling there extremely painful.

The hygiene of this relatively inaccessible, dark, warm, skin-lined tube is almost universally inadequate, making the accumulated secretions an ideal culture medium for bacteria, molds and viruses.

The epithelium of the meatus acousticus externus is delicate, easily traumatized, exquisitely sensitive and may bleed when touched even gently.

The excretory ducts from the secretory segments of the ceruminous glands empty either onto the free surface of the skin or into the excretory ducts of the sebaceous glands. As with other excretory glands of the body, the ducts of these glands may become occluded by retention of their secretions, often resulting in infection.

Cerumen (earwax) consists of yellowish-brown pigment particles and granules resembling fat. It is thought to have antibacterial and antifungal properties by virtue of the acid pH developed by production of fatty acids of fermentation.

The length of the auditory meatus in the infant is but slightly less than in the adult.[32] Negroes have short, wide canals and rarely have acute external otitis.

About seven millimeters from the eardrum, the lumen of the canal is constricted. Masses of dried cerumen and sebaceous secretions pushed in from the outer, secreting half of the canal, together with exfoliated epithelial cells, often become impacted in the space behind this isthmus, the tympanic sulcus, where infection with bacteria, molds and viruses may occur, plugging the lumen of the canal and resulting in chronic or acute inflammation.

ETIOLOGY

Acute external otitis is not a single disease entity. The many and diverse statements concerning etiology may be explained in part epidemiologically. In hot, humid, tropical and subtropical localities, the fungi predominate; in cooler, less humid locations external otitis is more frequently caused by bacteria. It is most prevalent in hot, humid weather, and especially in seaside communities.

In recent years (due to the increase in use of antibiotics) fungi, particularly *Aspirgillus niger* and *fumigatus* and *Candida albicans,* are becoming more prominent as factors in external otitis.

It appears probable that trauma to the epithelial lining of the canal and change in the normally acid pH at the skin surface to alkaline pH are necessary for the establishment of infection.

Alkalinity of the skin, including that of the ear canal, is unphysiologic. The normal pH of the cutaneous surface of the external auditory canal is in the acid range; in external otitis [12] the pH becomes alkaline,[15] varying between 7.1 and 7.8. One of the cardinal principles of therapy is restoration of the normal acid pH by instillation of acetic and other acids.

The common causes of trauma are the self-attempts to remove impacted cerumen with matchsticks, toothpicks, hairpins, bobbypins, eyeglass temples or ear spoons; scratching the canal with the fingernail; introduction of foreign bodies—glass beads, buttons, peanuts, and so forth; insects, and iatrogenic instrumentation. Long periods of using ear phones and tight headgear of nuns and orientals have been assigned etiological roles.

External otitis may originate as a manifestation of a generalized body dermatosis, in which case the maceration and sogginess of

the epithelium does not extend clear back to the eardrum as in swimmer's ear. To determine the nature of such a primary dermatosis the entire integument, including the hair and nails, must be examined, resorting to skin biopsy when indicated. External otitis has been referred to as the meeting place of otology and dermatology.[1]

Anatomic peculiarities may favor development of otitis. A canal of narrow lumen is readily plugged by moderate accumulation of debris, and a patient with a retracted tragus, forming a sort of operculum over the meatal orifice, is a candidate for otitis externa.

Otitis is more common in summer than in winter and more common in swimmers, especially in polluted water. Wax in the ear absorbs the water, macerating the skin of the canal and making it susceptible to infection.

Identification of an organism, bacterial or fungal, in the ear canal does not necessarily establish its etiologic role. The normal ear contains many organisms, resident and transient, which, for the most part are non-pathogenic, except when present in great quantities or when continuity of the integument is broken.

The normal canal harbors, as residents, staphylococci, micrococci, diphtheroids and corynebacteria, and, as transients, coliform bacilli, sarcinae, hemolytic clostridia, nonhemolytic streptococci, proteus and gaffkya. The bacteria demonstrated most frequently in cultures from the infected ear canal are *Pseudomonas aeruginosa, Escherichia coli, Proteus vulgaris, Streptococcus pyogenes,* and *Staphylococcus albus* and *aureus.* Proteus, staphylococci and streptococci are found in greater numbers in the inflamed than in the normal ear.

Fungal otitis was described more than a century ago. More than fifty different species of fungi have now been identified in otomycosis. The pathogenic fungi important as etiologic agents in otitis externa include *Aspergillus niger* and *fumigatus,*[19] *Candida albicans,* and certain species of penicillium, actinomyces and saccharomyces.

DIAGNOSIS

The diagnosis of acute external otitis is usually simple. The patient is in such excruciating pain as to make examination difficult or impossible without sedation. The whole side of the head aches and throbs. The tragus may be swollen, hot and tender. The temperature may reach 104 degrees F. The auditory canal may be occluded by swelling or by secretions and exfoliated epithelium making treatment difficult. There may be a purulent, sticky, yellowish discharge with a repulsive odor, and loss of hearing by interference with air conduction—"blocked ear." The canal, when seen, appears red and dry instead of pale and moist as normally. The drum, if visible at all, may be red like the canal or of normal color.

In mycotic infection, itching is a prominent symptom, caused by exotoxins produced by the mold growing saprophytically in the skin and drawing its sustenance from the intercellular cement substance. As the mold grows, the superficial layers slough off into the lumen, gradually filling it with a putty-like mass of mold and epithelial cells. The black spores of *Aspergillus niger*[27] or the greenish blue pus, with distinctive odor, of *Pseudomonas aeruginosa* infections may be present.

Intralabyrinthine pressure may stimulate the auricular branch of the vagus nerve, which, through its central relation to the vagal nuclei, may cause spontaneous or instrumentation-induced coughing, sneezing, nausea or even vomiting or convulsions.

The only real difficulty in the diagnosis is to make certain that the condition is primarily one of the external ear and not otitis media. Both conditions may be accompanied by fever; both may show a discharge. That from otitis media gains access to the external canal by penetration of the eardrum. Movement of the pinna or tragus causes excruciating pain in *external otitis* and none in *otitis media.* The canal is swollen in external, but not in internal, otitis. Regional lymphadenopathy is more frequent in external otitis than in otitis media; swollen lymph nodes behind the ear pushing it forward may elicit a false diagnosis of sub-

periosteal abscess from acute mastoiditis. The node just in front of the tragus is often palpable in external otitis. In external otitis, the drum is normal or red; in otitis media, it is bulging or may be perforated. Hearing acuity is normal or decreased in external otitis; it is always decreased in otitis media. External otitis is more frequent in summer; otitis media in winter.

The number of "idiopathic" cases can be reduced by a thorough study of each case—direct smears, cultures and organism susceptibility tests. Microbiologic laboratory identification of the organism in acute otitis externa is academically essential to rational treatment. However, by the time bacteriologic, mycologic and virologic studies can be completed the patient is well on the way to recovery with the effective modern methods of empiric therapy.

Fortunately, with experience in the management of otitis externa the physician soon comes to know which organisms are usually responsible in his locality and to which anti-infection remedies they respond. In the author's cases, laboratory studies almost invariably reveal *Staphylococcus aureus, Escherichia coli, Streptococcus beta-hemolyticus, Aspergillus fumigatus* and *Candida albicans,* and only occasionally the organism usually reported by others to be most frequent, *Pseudomonas aeruginosa.* Therapy is, therefore, directed toward these predominating organisms.

As an additional refinement of laboratory diagnosis, determination of organismal strain sensitivity to available antibiotics and other remedies is sometimes suggested. Such time-consuming studies are of more academic than practical therapeutic interest.

In taking the patient's history attempt should be made to determine the source of infection. It may be assumed, for the purpose of starting therapy (and until a contrary laboratory report is received), that the predominating organisms are those found in previous patients using the same pool or other contaminated waters.

TREATMENT

IN THIS self-limited disease "most of the infection will resolve spontaneously if the patient can be induced to leave it alone and the practitioner can control his therapeutic ardour."[28] But this spontaneous resolution might take weeks or months. In the meantime the patient would be incapacitated. It is the function of the physician to relieve suffering and to control infection with maximum speed and meanwhile to keep the patient normally active. To this end practically every known sedative, antiseptic, anti-inflammatory,[23] antibacterial,[6] antifungal[2,5] antibiotic,[7,8] corticosteroid[4] and physiotherapeutic[26] modality have been applied to the treatment of acute external otitis, singly and in combination.[3]

Among the older remedies, some of which are still in use, are: iodine, ichthyol,[21] silver nitrate, alcohol, boric acid, gentian violet,[17] aluminum acetate, and so on. All the sulfonamides, antibiotics[9,10,14] and adrenocortical derivatives were used, alone and in combination, as they were developed.[1]

Recently acid preparations are being preferred, for the purpose of restoring the natural acid pH of the skin of the aural canal by neutralization of the alkaline products secreted by the invading organisms. Acetic acid has gained favor, not only for its acidic nature but also for the asserted virtue of the acetic radical itself.[21,25] Changing the unphysiologic alkaline 'mantle' to the physiologic acid 'mantle' is accomplished also by sulphur dioxide, as gas or in solution as sulphurous acid,[18] undecylinic acid, boric acid, salicylic acid, isoparaffinic acid or aluminum acetate.

All the sulfonamides, single, double and triple, have been tried alone and in combination with bacteriostatic and fungistatic antibiotics. New preparations appear on the market in a continuous stream. Antibiotics in fungal infections of the ear canal increase the growth, making the condition worse. Antibiotics used locally may cause undesirable sensitization, precluding later and more necessary use. The antibiotics least likely to produce sensitization are bacitracin, Neomycin® and Poly-

myxin®-B, all of which are effective against the usual bacteria and do not sensitize to the more commonly employed antibiotics which may be used subsequently.[10]

Adjunctive therapy includes the use of aspirin or other sedative analgesic, or codeine if required, for pain control. In extreme swelling enzymic drugs directed toward fluid absorption, such as Varidase®, are useful. Correction of systemic factors, as in some generalized dermatoses, may sometimes do more toward cure than any local therapy.[15] Conventional dermatologic therapy, appropriate for other parts of the body may be used in the ear canal with the necessary modifications for the close quarters involved.[26]

To simplify and to standardize (as far as possible) the problem of therapy of acute external otitis, and to select from the host of available drugs, the following program has been developed in a step-by-step procedure. This has proved effective over a period of years. Similarly good results can be obtained from this program by others, at least along the central eastern seaboard of the United States where the etiologic flora may be assumed to be comparable to that encountered in this study.

Step 1—A smear and a culture are taken from the canal for laboratory determinations of the etiologic organisms, and of their susceptibilities to the proposed anti-infective drugs.

Step 2—The canal is cleared of debris and cleaned by irrigation and lavage with hypertonic salt solution, by aspiration or by gentle blowing with compressed air. Swabbing and cotton wicks are used carefully. A cotton wick is inserted into the canal and moistened with a medicine dropper with 4 to 8 drops of Cresatin,* as antiseptic, with 1 per cent thymol, as analgesic. This requires five to ten minutes. The wick is then removed and the canal again cleared of all debris.

Step 3—A second wick is inserted and moistened with 5 to 8 drops of a 5 per cent solution of glacial acetic acid in 95 per cent ethyl alcohol. This wick is left in the canal for 24 hours and is kept moist with VoSol Drops** by the patient.

Concurrently, intensive oral therapy with antibiotics of wide bactericidal and fungistatic properties is prescribed, either singly or in combination as indicated by an estimate of the causative organisms. In this study, the bactericidal antibiotic used was Declomycin,** the fungistatic antibiotic was Nystatin** and the combined antibiotic was Declostatin.**

Step 4—On the second day, the procedure of the first day (with the exception of smear and culture) is repeated. On the third day the wick is removed and the patient is instructed to use 5 drops of the otic solution in the ear four times a day, and (as prophylaxis) to use the solution in *both* ears before and after each swimming period. All types of ear plugs are forbidden.

The following typical case reports illustrate the speed of recovery under this program:

CASE ONE

A 13-year old boy, with otitis of the right ear, had been treated for two weeks without improvement. His temperature was normal. The right ear canal was swollen and painful, with a greyish-white discharge. There was great difficulty getting the first wick into the ear as the lumen was completely closed and he was experiencing great pain. With the aid of 1 per cent thymol in metacresylacetate, the wick was finally inserted and the four routine steps carried out. For the swelling of the canal Varidase® buccal tablets were prescribed four a day for two days. As adjunctive therapy, Declostatin,** three capsules a day were prescribed for 14 days. The patient was maintained on VoSol** otic solution as a preventive with no sign of recurrence despite his continued swimming and other accustomed activities.

CASE TWO

A lifeguard, aged 21, had a severe bilateral external otitis. Laboratory studies revealed a primary fungal etiology with secondary *Staphylococcus albus* infection. Furunculosis had developed, requiring lancing and drainage. The organisms were resistant to therapy because the patient had to be in the water every day. The routine four-step therapy was applied. Erythromycin, one Gram a day was prescribed as adjunctive to the routine topical therapy. Both ears cleared in ten days in spite of daily exposure in the surf.

This step-by-step routine topical therapy, together with appropriate adjunctive oral sedatives and antibiotics and a buccal fluid absorbent, used successfully in more than 150 cases of acute external otitis in the past few years, has kept lifeguards on daily active duty, and has enabled other patients to pursue their accustomed activities with minimal inconvenience.

*Cresatin®, metacresylacetate, NNR 1951. Merck Sharp and Dohme. Available in one ounce bottles.

**VoSol Drops®: propanediol diacetate, acetic acid and benzethonium in propylene glycol. Wampole.

Declomycin®: chloro-demethyltetracycline. Lederle.

Nystatin®: (Nystan, USP, NNR 1960). Squibb.

Declostatin®: Declomycin 150 milligrams with nystan. Lederle.

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A bibliographic list of 32 citations appears in Dr. Holland's reprints.

David S. Greenbaum, M.D.

Edwin V. Olmstead, M.D.

Flemington

Esophageal Moniliasis Without Thrush*

An unsual case of esophageal moniliasis without evidence of thrush is reported. Nystatin seemed to be a useful antibiotic in this case.

Monilial infections occur frequently[1-5] when diseases of the hematopoietic system and their complications are treated with long-term courses of antibiotics and/or corticosteroids or ACTH. Oropharyngeal moniliasis is often found but esophageal and gastrointestinal involvement is only occasionally diagnosed clinically[4,5,6] although such lesions are rather commonly found at autopsy. There are case reports[7] in which the disease was found by endoscopy,[8] autopsy or by finding the fungus in esophageal secretions[9] although the esophagrams were normal or were not mentioned. Wolff *et al.*[10] ascribed pharyngeal incoordination in infants to thrush esophagitis but did not mention abnormalities of the esophagrams. In recent years the radiographic appearance of esophageal moniliasis has been described[11 to 20] in both the European and American literature. Circular and oval filling defects causing a ragged appearance of the esophageal margins are typical. We present a case.

Monilial esophagitis was suspected from the patient's symptoms and the radiographic findings. Cultural and histologic examination of a vomited pseudomembrane confirmed the suspicion. Treatment was considered successful because of the improvement in serial esophagrams, the failure to grow fungus after vomiting the pseudomembrane and the relatively normal gross and histologic findings at autopsy 2½ weeks after the last course of mycostatin.

A 30-year old married woman was admitted to our hospital* with a history of one week of fever, chills and a cough productive of purulent sputum. Penicillin and tetracycline had been given prior to admission. She had lost 30 pounds over several years and had been told that her "blood was low." Chest x-ray 5 months prior to admission showed a density in the right upper lobe suggestive of tuberculosis. This was not confirmed bacteriologically. The remainder of the history was non-contributory. Last menstrual period had been six weeks prior to admission.

She was a pale, chronically ill woman with a temperature of 99. A small gingival ulcer was seen above the left first upper molar. Several small, firm, shotty, submandibular and axillary lymph nodes were palpable. The remainder of the examination was normal.

Hemoglobin was 6.8 Grams per 100 milliliters; hematocrit 21 per cent; RBC 1.99 million; WBC 2,000; polymorphonuclear leukocytes 4 per cent; lymphocytes 88 per cent; monocytes 2 per cent; eosinophils 2 per cent; ESR 24 milliliters; and platelets 86,000. Bone marrow aspiration was consistent with lymphatic leukemia. The remainder of the laboratory data were normal. Chest x-ray demonstrated linear densities in the right upper lung field.

The patient ran an intermittent fever between 99 and 100. Intermediate strength PPD intradermal test was moderately 2-plus positive. Because of the possibility of tuberculosis, isoniazid, and para-aminosalicylic acid, were started pending report of gastric aspirate cultures. She was discharged 13 days after admission symptomatically improved after a transfusion of 2 units of whole blood.

*From the Hunterdon Medical Center, Flemington, New Jersey.

Second admission was six weeks later. Now she complained of nausea, vomiting, weakness and occasional epistaxis. Physical examination and hematologic studies were similar to those of the previous admission. Cultures of gastric aspirates were negative for tubercle bacilli. Antituberculosis medications were discontinued. Intermittent vomiting continued. The obstetrical consultant diagnosed a 12 or 13 week intrauterine pregnancy. She improved and it was decided to withhold steroids until her condition further deteriorated. After 8 days she was discharged, following several blood transfusions.

One week later, she returned with recurrent bleeding from the gums and a temperature of 105.6. Chloramphenicol was started after a coagulase positive M. pyogenes had been cultured from the nose. Prednisone was also administered at this time. She was discharged after five days with remission of the fever. She was back seven days later with severe pain in the throat and upper chest, accentuated on swallowing solids. The liver edge was felt 4 centimeters and the spleen edge 2 centimeters below the costal margins. There was frequent vomiting of clear, occasionally blood-streaked mucus usually shortly after eating. Elixir of Benadryl®, non-absorbable antacids and codeine sulfate had little effect. An esophagram on February 4, 1959 disclosed numerous large round and oval filling defects which distorted the mucosal pattern. Clear mucus aspirated from the esophagus was cultured on corn meal medium and subsequently grew out Candida albicans. Mycostatin®, 250,000 units, four times a day, was started on the seventh day. This was doubled four days later and continued for five days. Xylocaine® 30 minutes before each meal and at bed-time afforded some relief of the chest pain. Four days later, she vomited several masses of wrinkled, yellow-gray material, resembling thickened esophageal mucosa. The largest fragment measured 11 by 2.5 by 0.2 centimeters. This pseudomembrane was composed almost entirely of C. albicans mycelia lying in a matrix of fibrinous material. Coagulase positive hemolytic M. pyogenes was cultured from the mass. Cultures of esophageal secretion obtained the day after the pseudomembrane was expelled did not yield C. albicans. An esophagram two days later was normal except for a few irregularities of the margins. Shortly thereafter the odynophagia diminished and the patient became more cheerful. The vomiting continued but she usually retained her meals.

She was discharged from the hospital only to be readmitted a few weeks later. Now she had a left otitis media and externa from which M. pyogenes was cultured. On the same day a small pseudomembrane was vomited and Mycostatin® was reinstituted. A left mastoditis developed followed by a facial nerve palsy and she was treated with penicillin, streptomycin and tetracycline. Prednisone was continued; the dose was later increased. After 50 days she was discharged.

A pseudomonas infection of the left eye and adjacent structures precipitated the last admission one week later. Bacitracin ointment was applied to the area. She was given penicillin intravenously as well as streptomycin and chloramphenicol orally. Prednisone was continued. On the fourth hospital day labor started and a premature male infant was delivered. Shortly thereafter her blood pressure fell and the temperature rose to 105.6. She died ten days after admission and six days after birth of the infant.

At autopsy we saw innumerable ecchymoses of the skin; the left eye was ecchymotic, swollen and eroded. A cavity containing yellow granular material was found in the right upper lobe.

The esophagus appeared grossly normal except for a shallow depressed area, 1.0 by 0.4 by 0.2 centimeters. This was 10 millimeters above the gastro-esophageal junction. There were many shallow, superficial, serpiginous ulcers 3 to 10 millimeters in diameter in the gastric antrum. The small and large bowel were unremarkable. The liver weighed 2800 Grams but was grossly normal. The spleen weighed 260 Grams; it was moderately soft and there was a loss of its usual pattern. The abdominal and thoracic lymph nodes were slightly enlarged. The bone marrow was not grossly remarkable.

At microscopic study we found bizarre "blast" cells throughout the epicardial fat, myocardium and pulmonary alveolar wall. The cavitary lesion in the right upper lobe was lined with fibrous tissue. Periodic acid Schiff and Gram stains failed to reveal bacteria or fungi.

The esophageal mucus membrane was slightly thinner than usual in the depressed area described grossly. It had the histologic characteristics of a re-epitheliazed ulcer. A diffuse sprinkling of lymphocytes, eosinophils and bizarre cells were found in the edematous thickened subepithelial tissue of the esophagus. Mycelia could not be demonstrated with the hematoxylin and eosin or periodic acid Schiff stains. The gastric ulcers did not extend beyond the epithelium. There were many cellular infiltrates in the gastric mucosal interstitium similar to those in the esophagus and no mycelia were found. The bowel was normal.

A diffuse scattering of "blast" cells and large amounts of hemosiderin pigment, mainly within macrophages, were found in the lymph nodes and spleen. The bone marrow consisted predominantly of large mononuclear "blast" cells; the normal elements were almost completely absent.

Esophageal moniliasis was suggested by severe odynophagia in the setting of acute leukemia. Bernay and Houver[8] have emphasized the "burning" sensation in this entity. The first esophagram revealed oval and circular radiolucencies similar to esophageal varices; however, there was nothing to suggest portal hypertension since the hepatosplenomegaly seemed explained by the leukemia. The radiographic abnormalities presumably were caused by the pseudomembrane rather than by significant esophageal wall destruction since the

esophagram was almost normal two days following evacuation of the pseudomembrane and only minor abnormalities were found at autopsy three months later. Two cases reported by Kaufman, Scheff and Levine showed normal esophagrams [15] after one week of Mycostatin®. Ebbs [7] described superficial esophageal ulceration in infants although mycelia sometimes penetrated the wall below the muscularis mucosae. Deeper ulceration sometimes resulting in stenosis has been described in other cases.[13,14,19,20]

It is not wholly certain that nystatin† was responsible for the favorable outcome of the esophagitis. The mild recurrence might have been prevented by a longer course of the drug. Bernay and Houver [9] felt it to be the drug of choice, most effective when held in the mouth before swallowing. One of Andren and Theander's cases [11] spontaneously subsided and Stenderup's cases [17] had good results after Pentamidine®. Hogewind and Hogewind's patient [12] apparently did not respond to Mycostatin® given with gentian violet, hydrogen peroxide and potassium permanganate. Recently successful results have been reported [18] in four out of five cases treated with Amphotericin B®.

Descriptions of esophageal moniliases without the oropharyngeal diseases were found in only six cases in the American [9] and European [13 to 16] literature. Fungi were not demonstrated in two of these.[15,16] The data did not always indicate whether the patients had symptoms or whether the diagnoses was considered clinically. Of the 17 cases with esophageal disease where definite notation of esophagrams were made, five were interpreted as normal.

Although the patient soon died of leukemia the odynophagia from the esophageal moniliasis was alleviated. The treatment of the fungal infection, of course, had little or no effect on the leukemia although monilial sepsis may have been prevented. It is important to diagnose this esophageal disease since an effective mode of treatment seems available.

SUMMARY

A case of acute lymphatic leukemia with esophageal moniliasis without evidence of thrush is presented. This entity is infrequently clinically diagnosed. The fungus infection was diagnosed before death by radiography, by cultural examination of the esophageal aspirate and by histological evaluation of a vomited esophageal pseudomembrane. The outcome of the esophagitis was favorable, possibly because of the use of nystatin†. Although esophageal moniliasis often accompanied fatal illnesses, treatment may offer the patient relief from distressing symptoms.

†We used the Squibb brand, trade named Mycostatin®.

We gratefully acknowledge the cooperation of Dr. Stephen B. Dewing, Director of Radiology, and Dr. Pauline R. Goger, the patient's physician.

Hunterdon Medical Center

A bibliographic list of 20 citations and 4 figures appear in the authors' reprints.

X-Ray Diagnosis of Arsenic Poisoning

Arsenic trioxide appeared as a barium-like radiopaque material on a roentgenogram of the abodmen. A case is reported in which a flat film of the abdomen led to the correct diagnosis of arsenic poisoning in a case of acute gastro-enteritis. The authors emphasize that valuable time may be saved and treatment instituted even before chemical confirmation.

R. J. Hilfer and A. Mandel, New England Journal of Medicine, 266:663 (March 23, 1962).

John N. Pannullo, M.D., *et al.***

Newark

Methyclothiazide in Pregnancy*

Its Diuretic and Antihypertensive Effects

Methyclothiazide was found to be a safe and effective diuretic in the control of edema and reduction of toxemia in 200 pregnant women in this study from the Martland Medical Center.

A number of reports have appeared about the use of benzothiadiazine diuretics in pregnant patients. Finnerty [1] and his colleagues studied the effects of chlorothiazide in 144 patients with edema, hypertension, or toxemia associated with pregnancy. Landesman, *et al.*,[2] found chlorothiazide a safe, potent oral diuretic for use in such patients. Zuspan, *et al.*,[3] presented the results of using both hydrochlorothiazide and dihydrotrichlorothiazide in ambulatory and balance-ward patients. No clinical difference was noted between the compounds employed. Schmitz [4] and his colleagues used hydrochlorothiazide in 124 patients with edema and/or toxemia of pregnancy. Lakin, *et al.*,[5] studied the effect of chlorothiazide on the insulin requirements of pregnant diabetic women. This group of investigators used diuretic agents as an integral part of the regimen in pregnant diabetic patients to prevent the formation of polyhydramnios.

The following report presents the results of using methyclothiazide† in a series of 200 pregnant patients for the control of the edema of pre-eclampsia.

Methyclothiazide is an analogue of hydrochlorothiazide. It is administered orally at a recommended daily dose of from 2.5 to 10 milligrams. Its diuretic properties are characterized by a marked increase in urinary volume, natruresis and chloruresis. The urinary excretion of potassium is increased only slightly. These effects probably result from inhibition of renal tubular reabsorption.

MATERIAL AND METHOD

Two hundred patients attending the prenatal clinic of the Martland Medical Center were selected for study. All had edema or other mild clinical symptoms of pre-eclampsia. Fourteen patients were definitely toxemic.

Methyclothiazide† was administered daily for seven days. For one hundred patients (Group I) a dose of 2.5 milligrams daily was arbitrarily chosen; the other one hundred (Group II) received 5 milligrams daily. All were advised to reduce the dietary intake of sodium. No drugs, other than methyclothiazide were used.

TABLE 1.

	Group I (2.5 mg./day)	Group II (5 mg./day)
Average age	23.4	23.8
Range of ages:		
13 to 20	32	35
21 to 30	56	48
31 to 39	12	17
	100	100

**This article was co-authored by M. Biondo, M.D., W. Weinstein, M.D., G. Deboni, M.D. and E. Goodkin, M.D.

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†Methyclothiazide was provided by Dr. G. H. Berryman, Abbott Laboratories, North Chicago, Illinois.

TABLE 2.

	Group I			Group II		
	(13-20)	(21-30)	(31-39)	(14-20)	(21-30)	(31-39)
Para 0	25	8	0	25	11	0
Para 1	4	12	0	5	10	1
Para 2	2	15	2	5	12	6
Parity of 3 or more	1	21	10	0	15	10

RESULTS

THE *edematous* status of all 200 patients prior to therapy is displayed in Table 3. Note that edema disappeared in all cases following one week of therapy with methyclothiazide. The average weight loss in Group I (on 2.5 milligrams per day) was 4.13 pounds (range, ½ to 12). The corresponding figures for Group II patients (5 milligrams per day) was 5.8 pounds (range, 1 to 13).

Five patients in Group I and two patients in Group II failed to respond with a loss of weight. Of the five patients in Group I, four gained an average of 4 pounds and one remained unchanged. Of the two patients in Group II who failed to lose weight, one gained one and three-quarters of a pound and the other gained 3 pounds during the course of therapy. We believe that these patients failed to take the medication as directed.

Six of the patients in Group I and eight of those in Group II were considered to be definitely *toxemic* due to a combination of edema, hypertension, and other clinical manifestations. Average age of these patients was 24 years. Eight were para 0; parity of the remainder was 1 to 3. Nine of these 14 patients had ankle or leg edema of grade 2-plus. The severity of the edema in the remainder ranged from a trace to 4-plus.

Edema disappeared in all 14 patients following one week of therapy with either 2.5 or 5.0 milligrams of methyclothiazide daily. The average weight loss of the six patients of Group I was 4 pounds. The eight patients of Group II lost an average of 5.3 pounds.

Prior to therapy the *blood pressures* of the 6 patients of Group I ranged from 140/70 to 150/98, with an average mean blood pressure (MPB)‡ of 102. Following one week of therapy at a daily dose of 2.5 milligrams, blood pressures ranged from 100/70 to 140/80 with an average MBP of 91. The average reduction in mean blood pressure‡ was 11.

Blood pressures in the 8 patients of Group II ranged from 140/90 to 150/100 prior to therapy. The average MPB‡ at this time was 109.5. Following a week of therapy at a daily dose of 5 milligrams, blood pressures ranged from 120/65 to 140/90 with an average MBP‡ of 96. The average reduction in MBP‡ as a result of therapy was 14.

The response to methyclothiazide in toxemic patients is shown in Table 4.

SIDE EFFECTS

NO SIDE effects of any kind were reported or encountered in any of the fourteen patients considered to be definitely toxemic. However, side effects were reported by eight of the 200 patients. Four in each group reported headache, weakness, dizziness, or vomiting. Interpretation of these complaints was difficult be-

TABLE 3.

EDEMA PRIOR TO THERAPY

Grade	Group I (2.5 mg./day)	Group II (5 mg./day)
0	3	1
Trace	9	6
Slight	4	0
+	31	17
++	40	54
+++	6	16
++++	1	6
Not recorded	6	0

‡MBP (mean blood pressure) is here defined as diastolic pressure plus one-third of the pulse pressure. Pulse pressure is the difference between diastolic and systolic. Some authorities define MBP as midway between systolic and diastolic, which would be a slightly higher figure than given by the formula used here.

TABLE 4.

RESPONSE IN TOXEMIC PATIENTS

Age	Parity	Edema	Wt. Loss	Initial B. P.	MBP	Final B. P	MBP
Group I Patients (2.5 mg./day)							
19	1/0	++	4.50	164/80	108	140/80	100
14	1/0	++	2.75	150/58	88	100/70	80
20	1/0	++	7.25	150/98	115	128/72	90
15	1/0	++	4.25	150/90	110	130/70	90
25	1/0	+++	2.00	140/70	93	120/80	93
29	4/3	+	2.75	140/80	100	124/80	94
20.3	Averages		3.91		102.3	Averages	91.1
Group II Patients (5 mg./day)							
18	1/0	++	5.75	140/90	106	134/75	95
26	2/1	++	2.50	144/96	112	136/80	98
26	5/3	++	5.00	150/92	111	120/90	100
21	1/0	++	7.00	156/90	113	130/70	90
22	4/3	+++	5.25	150/100	116	140/90	106
27	1/0	++++	6.00	140/90	106	120/65	83
32	3/2	++	6.50	140/90	106	120/70	87
38	3/2	Trace	4.50	140/90	106	140/90	106
26.2	Averages		5.31		109.5	Averages	95.6

cause of complicating or contributing factors such as the generally poor dietary and emotional status of these patients. In any event, it was not necessary to interrupt therapy in any case because of side effects.

SUMMARY

Methyclothiazide† was effective in the control of edema and prevention of excessive weight gain in 200 pre-eclamptic or toxemic patients. Edema of the legs and ankles cleared. Weight reduction averaged 4 to 6 pounds following the use of 2.5 and 5 milligrams per day respectively for one week. In six toxemic patients, average reduction in mean blood pressure following one week of therapy at the 2.5 milligram dose was 11 millimeters. The comparable figure for eight toxemic patients on a daily dosage of 5 milligrams for one week was 14 millimeters.

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Psychosomatic Profile • • •

From time to time, THE JOURNAL will publish in this space an item on psychosomatics of interest and importance to all medical practitioners. Contributions are invited and should not exceed 500 words each.

Pain and Emotion

Pain created the physician and surgeon. Seized by pains or by wounds, primitive man turned to those who possessed the skills to relieve his suffering. In contrast to this cause and effect origin for general medicine, psychiatry was a physician-created specialty. For, instead of the patient first seeking help, the psychiatrist turned to succor those who did not seek medical help and who had no awareness of abnormality. For centuries their mystifying aberrations were usurped from medicine and morally consigned to the domains of lawyers and theologians. In more recent times, because of Freud's contributions showing how pain can be a psychic symptom of unconscious conflict and much more than the appreciation of pin prick and response to specific nervous lesions, the psychiatrist has returned to the classical role of physician where his services are of value to the patient suffering with pain.

The family doctor may be baffled by a pain refractory to treatment or inexplicable in diagnosis. The possibility of "psychogenic" pain may be considered for: situations that have no reasonable anatomic or physiologic explanation, that persist beyond the expected time, that fail to respond to appropriate medication and are not relieved (or are intensified) by narcotics, or are alleviated by simple sedatives and hypnotics, or are seemingly miraculously assuaged by placebos, or are aggravated when the patient is discussing people and events of emotional significance in his life, and are eased when he is distracted.

The problem is often unraveled when the physician has knowledge of the patient's personal life and conditioning experiences. For example, hospital management of an irate, unreasonably demanding patient is easier when the physician knows something of his patient's childhood experiences. If such a patient had received tender solicitude, cold denial or harsh punishment from his parents for his childhood sufferings, he might unconsciously equate his current problem with the older forms of parent-child reaction and behave accordingly. Similarly, if such a patient when bed-ridden, dependent and regressed had observed, as a child, and secretly envied the sympathy given a sibling who had a chronic illness, this might have become an expected pattern for himself when disabled in later life. When his anticipated needs of tenderness are catered to he will have no complaints, but if this care does not conform to his preconceived notion of the earlier childhood pattern he might become a problem. As another example, not infrequently the frustrating pain problem of a patient who has failed to obtain relief despite countless drugs, polysurgery or an addiction to narcotics will give a lurid history of a masochistic quest for pain. However, the root of such a problem can often be traced to childhood situations where the patient learned to use pain as a means of punishment. Brought up in a strict and perfectionistis home, such a patient had to repress all angry and hostile feelings towards the sibling who was favored by the parents. When that favored and envied sibling was punished the patient's moral system was compromised and because of guilt over the secret enjoyment of his rival's adverse situation he learned to substitute a punishment of himself by developing the pain that he believes his sibling felt. When confronted with later life situations that might otherwise provoke open resentment or hatred towards somebody who reminds him of the earlier sibling, pain will result.

Unless these complex unconscious mechanisms are understood and the patient is respected and not ridiculed for his alleged "imaginary" pain, the physician might unwittingly become the agent of much harm. By failing to comprehend such psychodynamic pain, coincidental illnesses can be missed, diseases can be unnecessarily protracted, and conditions masked by a learned stoical reaction to pain can go unrecognized and unchecked. With early diagnosis and psychotherapy the physician can often relieve his patient and obviate many protracted pain problems, phantom pain, drug addiction, and the need for somatic psychiatric therapies as electroshock treatment and prefrontal lobotomy.

—Berthold E. Schwarz, M.D.

Book Reviews

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Postpartum Psychiatric Problems. By James A. Hamilton, M.D. St. Louis, 1962. Mosby. Pp. 156. ($6.85)

Since the adoption of the 1924 nomenclature, American psychiatrists have officially denied the existence of postpartum psychosis. The theory was that the puerperal state simply released some other latent psychosis, usually a schizophrenia or a manic-depressive attack. Consequently practically no one ever studied postpartum psychoses—why study something that doesn't exist?

In this well-written book, Dr. Hamilton provides the family doctor, obstetrician and pediatrician with diagnostic criteria for identifying the patient who will need special psychiatric attention after childbirth. More than that, he suggests what can be done for such patients. He emphasizes organic rather than functional therapies and is particularly interested in hormonal (especially thyroid) factors in this psychosis. Dr. Hamilton draws an ingenious analogy between postpartum and combat psychoses. In each, a stressful situation precipitates a psychotic episode which most psychiatrists consider to be the outcropping of a basic psychosis. In each, there are toxic-exhaustive-endocrinc factors. Both conditions may be associated with delirium.

The book is well organized, concise, scientifically sound and practical. It will—and should—stimulate further studies of an area long neglected. Even today, more than 4000 mothers a year develop postpartum psychoses. And with our rapidly increasing birth rate, this incidence will rise. Dr. Hamilton's text is supported by a rich and varied bibliographic citation list.

Florence Obuchowski, M.D.

Disturbances of Heart Rate, Rhythm and Conduction. By Eliot Corday, M.D. and David W. Irving, M.D. Philadelphia, 1962. Saunders. Pp. 357. ($8.50)

The authors state that their text is directed toward medical students and clinicians who require a physiologic foundation for the comprehension of disturbances of heart rate, rhythm, and conduction that may be used effectively in the practice of medicine. With this in mind, Corday and Irving present a simple and clear description of the electrophysiology of cardiac arrhythmias. They then give over a major portion of the text to the clinical problems of cardiac arrest, hemodynamic disturbances resulting from arrhythmias, and arrhythmias associated with myocardial infarction, surgery, anesthesia, and electrolyte disturbances. Separate chapters are devoted to bedside diagnosis and to emotional factors in cardiac arrhythmias. Especially commendable is the emphasis given to the hemodynamic effects of arrhythmias. Many examples are presented of the effects of arrhythmias on the cerebral, cardiac, mesenteric, and renal circulations.

However, the text suffers to some extent from oversimplification in the description and illustration of the arrhythmias and by the omission of a presentation and analysis of more complicated arrhythmias encountered too often in practice. The authors tend to dismiss concepts held by other serious workers without adequate presentation of controversial theories. These critical comments should not detract from the opinion that this is a good book for the group for which it was intended. It is not a reference work for the more experienced electrocardiographer.

William S. Karlen, M.D.

Introduction to Anesthesia. By R. D. Dripps, M.D., J. E. Echenhoff, M.D. and L. D. Vandam, M.D. Philadelphia, 1961, Saunders. Edition 2. Pp. 413, illus. ($8.00)

This edition covers most of the theoretical and practical aspects of anesthesia. It provides easy reading for the beginning student of anesthesia. In this field, much teaching is provided by word of mouth, passed on from individual to individual. This book provides a baseline from which the student can arborize his observations and questions of the teaching staff as individual problems arise during the course of a specific case.

The text starts with the pre-anesthetic period, carrying through the day of anesthesia, the operation and the postoperative period. It then covers resuscitation, the anesthetist as a consultant and includes material on instruction in anesthesia and malpractice. The authors provide an easily understandable description of the elements of an anesthetic machine, followed by a summary of the standards of storage of compressed gases as controlled by the Interstate Commerce Commission. Chapter 10 gives a brief characterization of each of the commonly used inhalation agents—cyclopropane, ethylene, ethyl ether, vinethene, trilene, ethyl chloride, chloroform and halothane, with a discussion of the technics of inhalation anesthesia.

The chemistry of carbon dioxide absorption and the physiologic effects of hypercarbia are dealt within individual chapters, as is "intubation of the trachea." Relaxants, intravenous barbiturate anesthesia, spinal, epidural and local anesthesia are each discussed to a limited degree. Both respiratory and cardiac resuscitation is described although the technic of "closed cardiac massage" is not included. Special methods such as hypotension, hypothermia and cardiopulmonary by-pass are presented with mention of some of the disturbances in physiology to be anticipated while utilizing these modalities. One whole section is devoted to the anesthetist as a consultant, bringing out the importance of his knowledge of physiology and clinical pharmacology in the care of the patient *outside* the operating room. The chapter on "Management of coma" presents a predetermined and rational plan of treatment with a description of an emergency kit.

Introduction to anesthesia is a well written and well organized book, instructive to all students of anesthesia. It provides a good list of references for guidance to further study of the multitude of topics covered.

CHESTER J. MODESKI, M.D.

Clinical Disturbances of Renal Function. By Abraham G. White, M.D. Philadelphia, 1961. Saunders. Pp. 468. ($10.50)

Dr. White has used a wealth of personal experience and research to provide this comprehensive and practical volume on altered renal function. Meant primarily for the practicing physician who is confronted with a patient with malfunctioning kidneys, it not only helps him diagnose and treat the individual problem with dispatch but also gives him a complete discussion of the anatomy and physiology involved.

This book can be used by the practitioner merely by reference to the appropriate chapter. One section is devoted to obstetrical aspects of renal dysfunction; others cover surgical, urologic and psychiatric aspects. There are separate chapters on cardiac and pulmonary, hepatic, hormonal and genetic influences on renal function. The nephritides, the nephrotic syndrome, hypertension and acute renal failure are also completely and individually discussed.

The introductory chapter gives good definitions and classifications. It clearly explains and gives excellent visual diagrams to elucidate renal hemodynamics, electrolyte exchange and body balance. It correlates these with signs and symptoms, diagnosis and treatment. The book includes chapters on the therapeutic use of water and electrolytes as well as on a discussion of clinical methods for evaluation of renal dysfunction.

A short appendix gives further discussion of renal anatomy and transport mechanism and also diuretic agents.

Numerous graphs, figures, pictures and photomicrographs illuminate the text. The bibliographies are held to a minimum but should enable one who wishes to pursue a particular point.

Dr. White gives all sides to disputed questions; yet he has not become lost in controversy. I recommend this volume as an up to date reference work on renal disease as well as one which the practitioner may study thoroughly with benefit.

JOHN F. VINING, M.D.

Quinones in Electron Transport. Edited by G. E. W. Wolstenholme, M.B. and C. M. O'Connor, B.Sc. Boston, 1960. Little, Brown. Pp. 453. ($11.00)

Oxidative phosphorylation is the process by which ATP formation from ADP and inorganic phosphate is tied up with electron transfer reactions. The mitochondria contain a complex system by which electrons removed from the substrate molecules oxidatively are transferred ultimately to molecular oxygen through intermediary carriers. These enzymes possess a specific "active group" capable of accepting electrons from the preceding member of the chain and of passing them along to the next. The active group of the known carriers are diphosphopyridine nucleotide, flavin adenine dinucleotide, attached to a protein, and four cytochromes. Perhaps as many as three additional enzymes are involved.

This book is the fruit of a Ciba Foundation Symposium. It includes the nineteen papers given there plus concomitant discussions by biochemists, microbiologists, physiologists and pathologists from Europe and America. The conference deals with the role of the lipid-soluble quinones as physiologic electron carriers.

The independent and simultaneous discovery of coenzyme Q by Dr. R. A. Morton in Liverpool and Dr. F. L. Crane in Wisconsin is described in detail by these biochemists. Outstanding papers describe experiences with the chemical characterization and synthesis of this quinone and related derivatives.

As a biochemist, this reviewer was particularly interested in a paper presented by Drs. V. M. Clark and Alexander Todd, who reviewed the chemical methods of phosphorylation reactions in the light of present-day organic chemical theory. Quinol phosphates undergo rapid oxidation resulting in the formation of the quinone. Clark and Todd suggest that quinol phosphates were the intermediates which link oxidation and phosphorylation reactions in the mitochondria.

Dr. Martius eloquently discussed his recent work on the chemistry and function of vitamin K. His discovery of a new flavoprotein (vitamin K reductase) which acts as an electron carrier between the reduced form of the pyridine nucleotides and vitamin K, aroused interest in the discussions which followed. Pigeons lack vitamin K reductase

and are insensitive toward vitamin K deficiency; this is not so for other birds.

With occasional exceptions, the quality of the individual contributions is extremely high; inaccuracies are rare. Most of the space is devoted to recent work, largely by the contributors, but the wide citation of earlier papers and reviews provides good total coverage. For investigators in any phase of the subject, this volume should be the first source of reference.

H. M. Bates, Ph.D

An Introduction to Clinical Medicine. R. H. Lovell, M.D. and A. E. Doyle, M.D. Baltimore, 1961. Williams and Wilkins Company. Pp. 115. No illustrations. ($3.50)

In didactic fashion, Dr. Lovell and Dr. Doyle spell out how to take a history and do a physical examination. There are tips on history-taking and an extremely detailed schedule for a thorough physical examination. The value of the book would have been enhanced by a few illustrations, charts or diagrams. The authors are Australian internists, and here and there some confusion develops because of differences in the American and British versions of the English language. The book is intended for medical students and interns, but it would not hurt any practitioner to have readily accessible a meticulous outline like this. A doctor who examines a patient the way these authors suggest will certainly not miss much. Some of the advice is a bit too general to be useful, as "Alcohol and tobacco are causally related to many diseases"; but then, for only $3.50 you can't have everything. The authors are to be commended for putting so much emphasis on normal findings—an important but often neglected aspect of medical training.

Ulysses M. Frank, M.D.

Instructional Course Lectures of the American Academy of Orthopaedic Surgeons. Edited by F. C. Reynolds, M.D. St. Louis, 1961. Mosby. Pp. 310 with 265 figures. ($17.00)

The first portion of the book presents an excellent review of the anatomy, physiology and pathology of disc disease and the neurosurgical and orthopedic management of this condition. There are three presentations of the conservative, early surgical and surgery in cervical spine injuries. This section is well worthy of review by both neurosurgeons and orthopedists or residents in these specialties.

Part two is devoted to fractures about the knee, fractures of the pelvis with fracture dislocation of the hip joint and contains an excellent section on fat embolism. Then there is a section on children's orthopedics, concerned with the tendon transpantation in the knee and foot, lower extremity reconstructive surgery in cerebral palsy or similar condition, congenital talipesequino varus and pes cavus, with the surgical reconstructive procedures used for each. The section on congenital dislocation of the hip presents a method of treatment of this condition with excellent results.

Part four is devoted to blood supply of bone with the surgical aspects encountered in various fractures, congenital dislocation of the hip, slipped epiphyses, fractures, carpal navicular, bone grafting and growth.

The next section includes articles on neurovascular syndromes about the shoulder and plastic surgery of the extremities. The most outstanding article is on the epidemiology of staphylococcal wound infections in previously clean surgical cases on an orthopedic service where the study recognized that postoperative hematomata were related to post-surgical infections, particularly in elderly, debilitated patients.

The instructional course volume is an excellent source of material for both the resident and the practicing orthopedic surgeon, and for all interested in this field. This volume, as those published in the past, still constitutes the best source of orthopedic material published in English and is superior in most respects to any standard textbooks because of its wide variety of subject matter and well-recognized authorities.

Edwin J. Otis, M.D.

Pathology. W. A. Anderson, M.D. St. Louis, 1961. Mosby. Ed. 4. Pp. 1389, with 1392 illustrations. (Price not stated)

The new 4th edition of Anderson's *Pathology* has been extensively revised. Several sections have been completely re-written. It maintains a complete and up-to-date coverage of all the aspects of pathology that can possibly be included within a single volume. The text maintains the general format of previous editions, but new chapters have been added. These discuss hypersensitivity problems, such as collagen diseases and certain new entities such as carcinoid syndrome, aldosteronism, familial chronic idiopathic jaundice and pulmonary alveolar proteinosis. There are many informative illustrations gained by the electron microscope. New knowledge culled from histochemistry is also presented.

The book has been authoritively written by 35 well qualified authors. It is invaluable to the student and to the practitioner who wants to expand his knowledge of pathology and correlate it with clinical findings. This book needs no introduction to the pathologist; for him, it is a necessity.

J. Forestiere, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

SEPTEMBER, 1962 • VOL. XXXV, NO. 7

INFECTIOUS PNEUMONIA, A CONTINUING PROBLEM IN DIAGNOSIS AND MANAGEMENT

Pneumonia may be caused by a variety of organisms, but the usual pathogens are bacteria or viruses. Clues to diagnosis may be found in the clinical, X-ray, or laboratory findings.

Infectious pneumonia may be caused by a variety of specific organisms, more frequently bacteria or viruses than rickettsiae or fungi. Primary infectious pneumonia applies to pneumonia that occurs as the initial illness; secondary infectious pneumonia applies to pneumonia that complicates a preceding disease process, the pathogen usually being bacterial.

Pneumococcus, still the most common cause of bacterial pneumonia, usually is responsible for a lobar-type reaction.

Staphylococcal pneumonia is usually lobular. The rise in the incidence of staphylococcal pneumonia in recent years may be due in part to staphylococcal superinfection in patients hospitalized for other illnesses.

Haemophilus influenzae, although capable of producing primary pneumonia, more often is a secondary invader. The reaction to Klebsiella (Friedlander's bacillus) pneumoniae, an infrequent cause of pneumonia, is typically lobar. Tuberculosis also is to be suspected in pneumonia involving the upper lobes of the lung.

Proved viral pneumonia has been due mostly to the adenoviruses or to influenza viruses, types A and B. This may reflect the relative ease with which diagnosis of infections due to viruses of these groups can be established by serologic methods. Since only a minority of viral infections are currently recognized by this method, the diagnosis of primary infectious pneumonia still depends upon the commonly used clinical and laboratory aids.

The recognized screening technic for all cases of pneumonia is the culture of sputum and blood specimens prior to antibiotic therapy. A bacterial diagnosis can usually be established in 24 to 48 hours. The fluorescent antibody technic appears promising for the early diagnosis of viral infections.

Roentgenographic findings are necessary to confirm the diagnosis of pneumonia and may shed light on the type of pneumonia. A diagnosis of bacterial pneumonia is usually justified when the roentgenogram reveals cavitation within an area of pulmonic infiltration or when broncho-pleural fistula or pneumatocele formation is present. Where there is a lag in roentgenographic change compared with pulmonary findings together with a bilateral lobular type of pneumonic involvement, viral pneumonia is suspected.

Clinically, bacterial pneumonia classically starts with a productive cough. In viral pneumonia, cough is generally absent initially or is dry and irritating, the main complaints being headache, myalgia, malaise, and fever. In bacterial disease, the pulse rate is rapid and correlates with the level of fever; in viral disease it tends to be slower than expected. In bacterial disease the response is usually favorable and prompt recovery is expected if a positive sputum culture is obtained and an appropriate antibiotic is administered. Since no agents of proved viricidal activity are com-

George W. Morrow, Jr., M.D.; Arthur M. Olsen, M.D.; William J. Martin, M.D.; *Proceedings of the Staff Meetings of the Mayo Clinic,* March 14, 1962.

mercially available at present, patients with viral pneumonia usually have a sustained fever for five to seven days.

In viral pneumonia the leukocyte count is usually normal; in bacterial pneumonia it is usually increased. The sedimentation rate of erythrocytes is elevated in both bacterial and viral pneumonia, with the more significant increase in viral disease.

Sputum culture usually gives positive results in bacterial pneumonia and negative results in viral, but results may be positive in the latter because of bacterial contaminants from the nasopharynx and therefore may be misleading.

TREATING THE PNEUMONIAS

In the management of the pneumonias, there is no substitute for clinical acumen combined with a thorough knowledge of antimicrobial agents and their potential application.

In pneumococcal infections, penicillin remains the agent of choice. In patients allergic to this agent, erythromycin base may be used.

In patients believed to have staphylococcal infection, dimethoxyphenyl penicillin sodium (Staphcillin), vancomycin, kanamycin, chloramphenicol, and novobiocin can be employed in that order of choice. As soon as results of cultures and *in vitro* susceptibility tests are available, the appropriate antibiotic should be substituted.

Since penicillin and dimethoxyphenyl penicillin sodium are cross allergenic, the latter cannot be used in patients with an untoward reaction to penicillin.

In infections due to Haemophilus influenzae, Klebsiella pneumoniae, Pasteurella tularensis, and Brucella, combined tetracycline-streptomycin therapy is effective. Tetracycline is used in rickettsial infections. Chloramphenicol should be avoided as much as possible because of its potential hematotoxicity.

For tuberculous pneumonia the combination of streptomycin and isoniazid is first choice, with para-aminosalicylic acid as a substitute for either.

The majority of primary pneumonias do not respond to antibiotic therapy, suggesting a viral causation. In patients not critically ill, one should therefore await reports on microbiologic studies before considering antimicrobial therapy. Fulminating staphylococcal pneumonia may be indistinguishable from severe viral pneumonia in the first 48 hours. Patients belived to have this type of pneumonia should be treated empirically with an antimicrobial to which staphylococci are known to be sensitive.

Because secondary staphylococcal invasion appears prone to occur in patients receiving the tetracycline or allied agents, which suppress the gram-negative elements of the normal body flora, tetracycline drugs should not be used unless other drugs are known to be less effective. In viral pneumonia, treatment at home should be considered since hospitalization may provide contact with virulent bacteria and the possibility of superinfection.

As for supportive therapy, oxygen therapy is specific for dyspnea and sometimes a tank resuscitator may provide life-saving support.

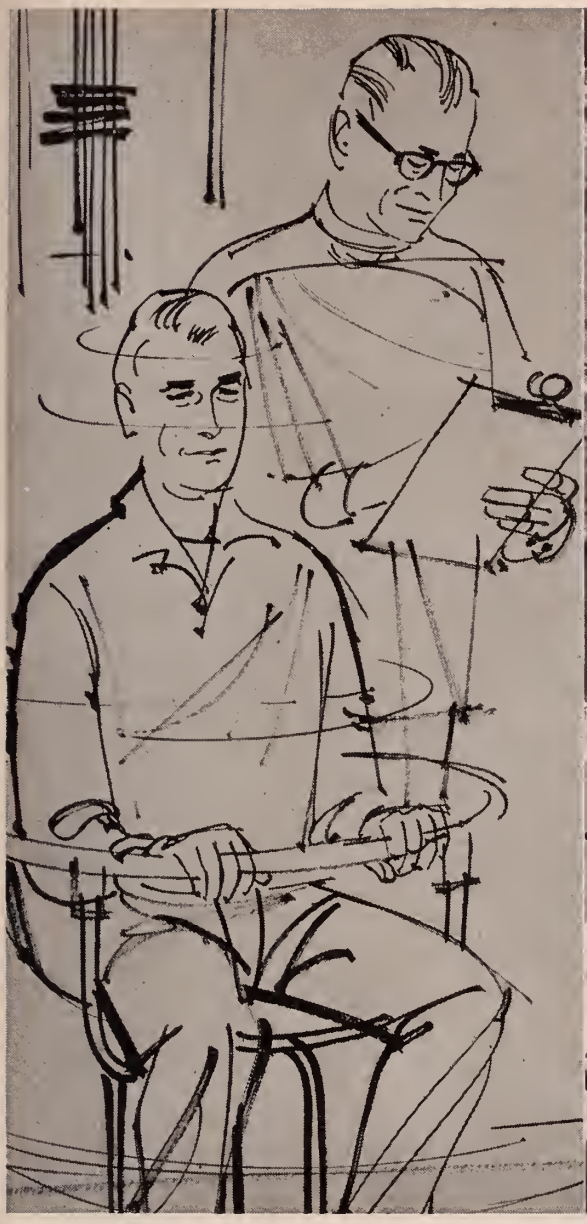
PROGNOSIS

Pneumococcal pneumonia still causes significant mortality. Staphylococcal pneumonia was the leading cause of death in many areas during the recent outbreak of Asian influenza.

Viral pneumonia is a self-limiting disease in most patients, with complete recovery. However, it may be the sole mechanism leading to severe hypoxia and death.

If the clinical course is unusually prolonged in pneumonia, or if the pulmonary infiltrate has not completely resolved by the fourth week, the possibility of a tuberculous basis, an associated systemic disease, or an underlying malignant process should be suspected.

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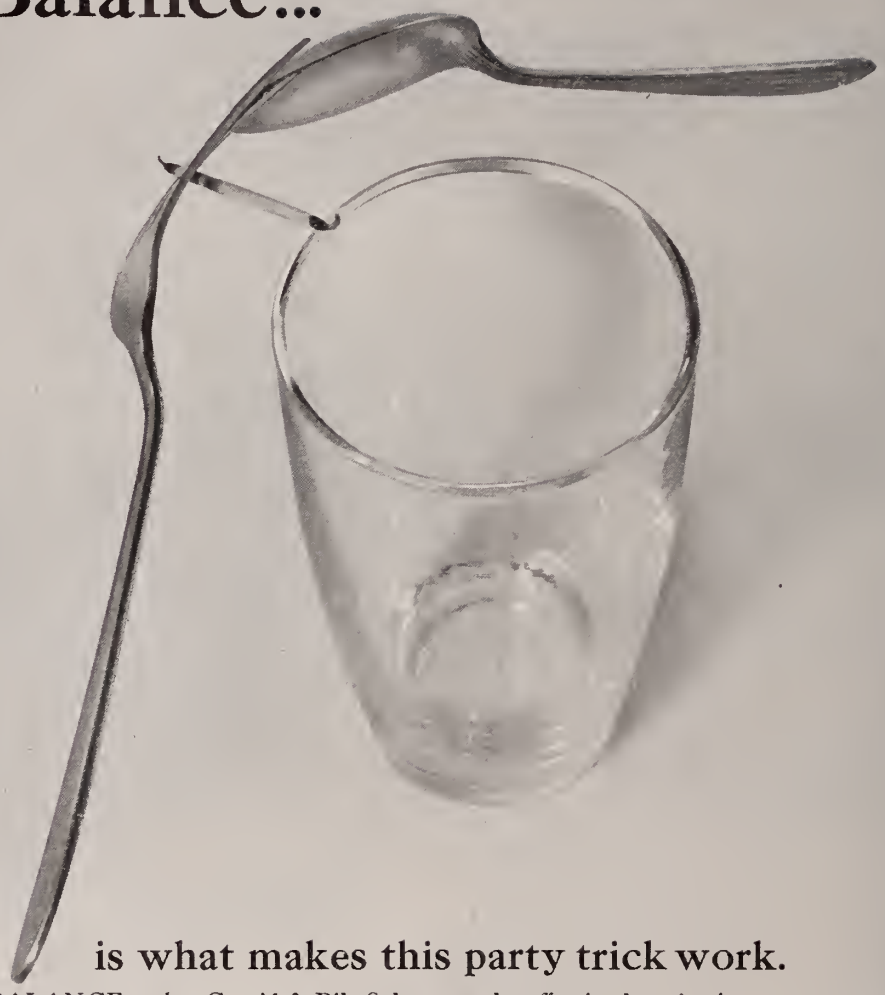
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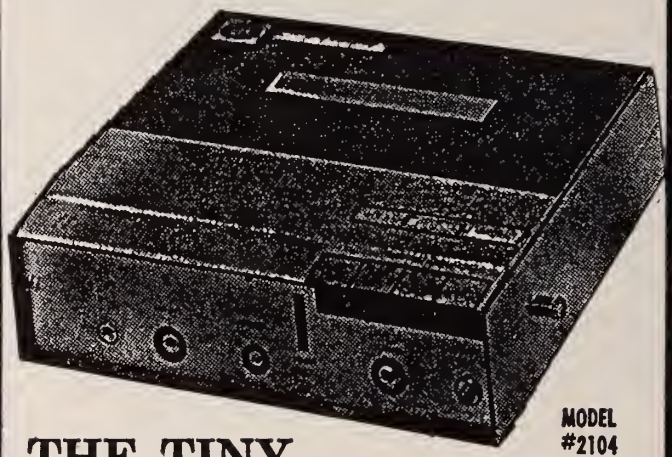
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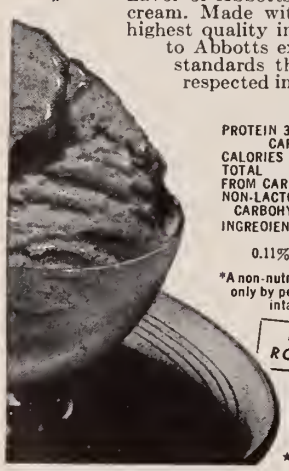
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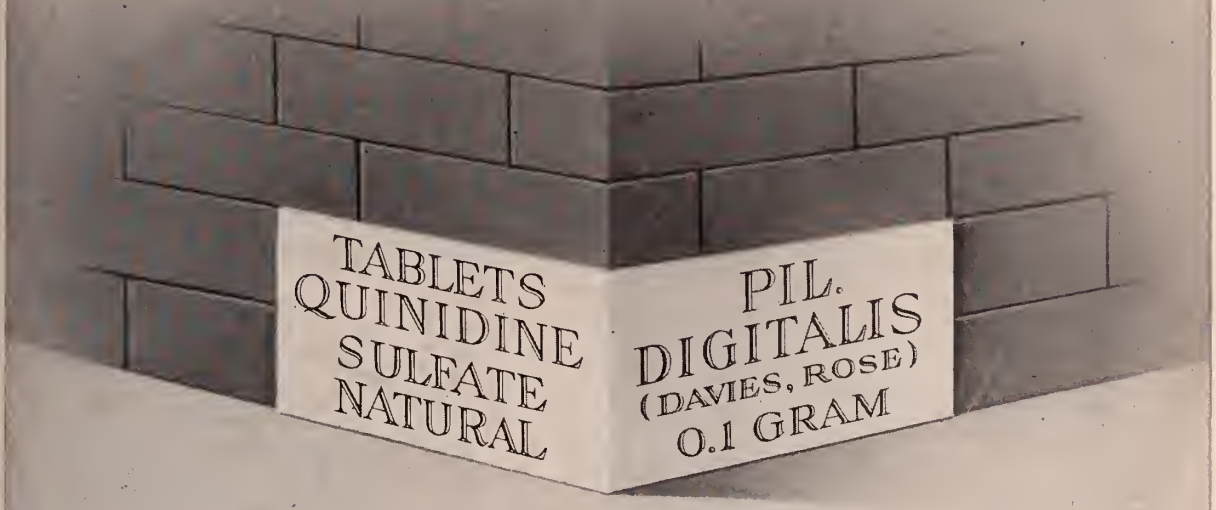
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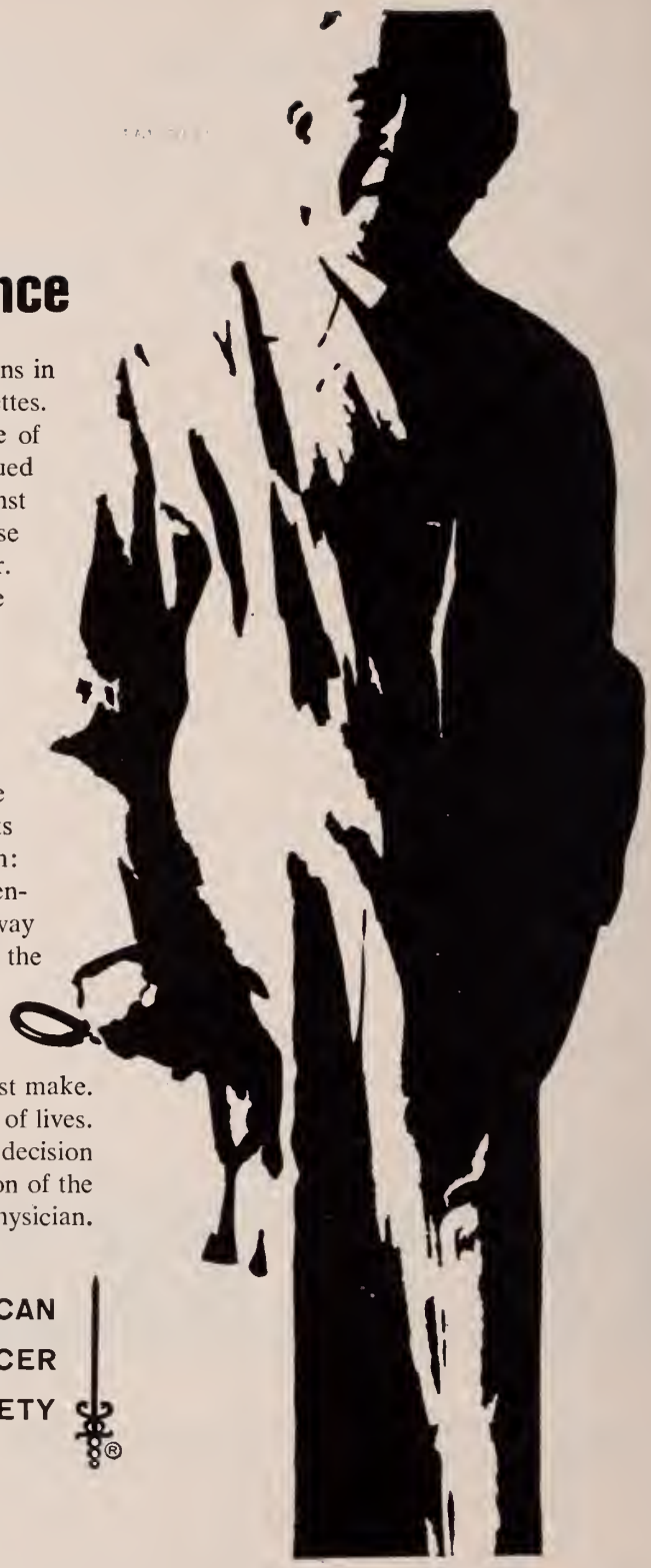
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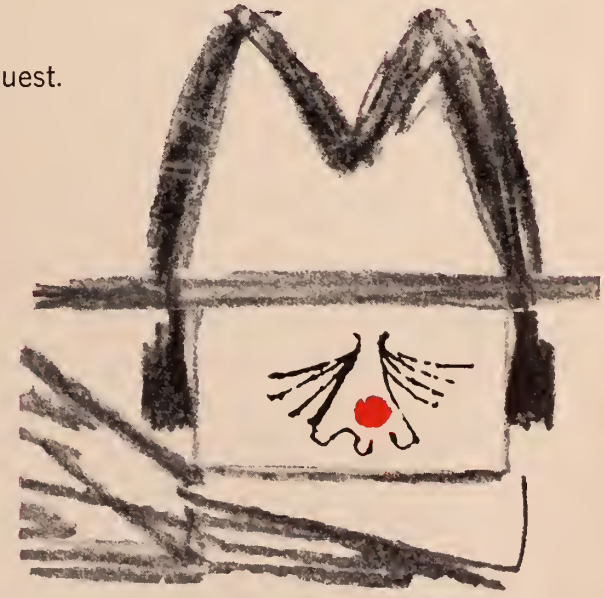
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Executive Officer (Richard I. Nevin, Trenton)
Equal representation from MSP and HSP

Bureau of Investigation, Department of Law and Public Safety, Cooperating Committee With

Board of Trustees

Chamber of Commerce Legislative Conferences

Executive Officer (Richard I. Nevin, Trenton)

Chronic Sick State Advisory Council (appointed by Governor)

William D. Kimler, M.D., Haddon Heights (1964)
Johannes F. Pessel, M.D., Trenton (1957)

Civil Defense Organization, State

Chairman, Committee on Disaster Medical Care (Jack R. Karel, M.D., Hillside)

Crippled Children and Adults, N. J. Society for— Statewide Sponsoring Committee

President (Louis S. Wegryn, M.D., Elizabeth)

Crippled Children Commission, State (appointed by Governor)

Frederick G. Dilger, M.D., Hackensack (1966)

Diabetes Detection Drive (1962)

John J. Torppey, M.D., Newark

Disaster Control, Joint Committee with Hospital Association

Special Committee on Disaster Medical Care

Directory Planning Committee, N. J. Conference on the Handicapped

Elmer J. Elias, M.D., Trenton (Chairman, Special Committee on Rehabilitation)

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Elton W. Lance, M.D., Vice-Chairman, Rahway
2nd District—John J. Bedrick, M.D., Bayonne
Robert A. Cosgrove, M.D., Jersey City
3rd District—Gerard R. Gessner, M.D., New Brunswick
John A. Kinczel, M.D., Trenton
4th District—Reuben L. Sharp, M.D., Camden
John C. Clark, M.D., Asbury Park
5th District—Nicholas E. Marchione, M.D., Vineland
John S. Madara, M.D., Salem
(Quorum: 4 members)

Education, Advisory Council to State Department of (appointed annually by Commissioner of Education)

Jess McCall, M.D., Newton

Education, Liaison with State Department of

Chairman, Special Committee on Child Health (Robert E. Jennings, M.D., South Orange)

Epilepsy, Advisory Panel on (to Director of Motor Vehicles)

Chairman, Special Committee on Mental Health (Robert S. Garber, M.D., Belle Mead)

Epilepsy Project, N. J. Consultation Service for Convulsive Disorders

Chairman, Special Committee on Mental Health (Robert S. Garber, M.D., Belle Mead)

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(Bylaws, Chapter IV, Section 5b.)

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Edwin H. Albano, M.D., East Orange
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Health Insurance Conference

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Historian-Archivist

Fred B. Rogers, M.D., Trenton

Hospital Advisory Council, State Department of Institutions and Agencies (appointed by Board of Control)

C. Byron Blaisdell, M.D., Asbury Park (1963)
Luke A. Mulligan, M.D., Leonia (1965)

Hospital Service Plan Liaison Committee

21 county advisory committees to MSP

Hospital Service Plan Board of Trustees (per HSP Bylaws)

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Hospital Survey Team, Special Committee on

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Carl A. Maxwell, M.D., Morristown
Thomas J. White, M.D., Jersey City

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Chairman, House Committee (L. Samuel Sica, M.D., Trenton)
Executive Officer (Richard I. Nevin, Trenton)

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Thomas K. Rathmell, M.D., Trenton
Eugene H. Kain, M.D., Camden
(With representatives from the State Department of Health, New Jersey Hospital Association, and New Jersey State Nurses' Association.)

Lay Health Organizations and Paramedical Groups, Official Intermediaries with

Members of the Council on Public Health as asasigned by the chairman.
(Assignment of official intermediaries from The Medical Society of New Jersey to lay health organizations and/or paramedical groups does not imply endorsement of the organization/group of its program.)

Legislative Keyman, National

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President-Elect (Jerome G. Kaufman, M.D., Maplewood)
Immediate Past-President (Ralph M. L. Buchanan, M.D., Phillipsburg)
Executive Officer, Ex-Officio (Richard I. Nevin, Trenton)
Equal representation from New Jersey Hospital Association and New Jersey State Nurses' Association

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Jerome G. Kaufman, M.D., Maplewood
Daniel F. Featherston, M.D., Asbury Park
Samuel J. Lloyd, M.D., Trenton
Ralph M. L. Buchanan, M.D., Phillipsburg
Louis S. Wegryn, M.D., Ex-Officio
Robert M. Backes, Ex-Officio

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Immediate Past-President (Ralph M. L. Buchanan, M.D., Phillipsburg)
Executive Officer, Ex-Officio (Richard I. Nevin, Trenton)
(Where number of representatives from other organizations is larger than number of Medical Society representatives, the latter will be increased from the Presidential Officers to equal the former.)

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Frank J. Hughes, M.D., Camden
Ralph M. L. Buchanan, M.D., Phillipsburg
Richard I. Nevin, Ex-Officio, Trenton

Medical-Surgical Plan Board of Trustees (per MSP Bylaws)

President (Louis S. Wegryn, M.D., Elizabeth)

Medicare Fiscal Agent

Medical Service Administration of New Jersey

Medicare Program, Special Committee on

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Nicholas A. Bertha, M.D., Wharton
Joseph R. Jehl, M.D., Clifton
L. Samuel Sica, M.D., Trenton

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Nicholas A. Bertha, M.D., Wharton
Lloyd A. Hamilton, M.D., Lambertville
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Motor Vehicles, Liaison with State Division of

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National Foundation Health Scholarship Committee

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Nutrition Council, New Jersey

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Chairman, Special Committee on House Maintenance, etc., (Louis S. Wegryn, M.D., Elizabeth)
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Andrew C. Ruoff, III, M.D., Pompton Plains
Robert M. Backes, Counsel, Consultant, Trenton

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Marcus H. Greifinger, M.D., Newark
Louis S. Wegryn, M.D., Elizabeth
(equal representation from New Jersey Hospital Association)

Public Health Association, New Jersey

Louis S. Wegryn, M.D., Elizabeth (Delegate)
Richard I. Nevin, Trenton (Alternate)

Safety Council, New Jersey State
(per Council Bylaws)

President (Louis S. Wegryn, M.D., Elizabeth)
President's representative: A. M. K. Maldeis, M.D., Camden

Seton Hall Chapter of Student AMA, Advisory Committee to

Joseph P. Donnelly, M.D., Jersey City

State Employees and Workmen's Compensation, Special Committee on

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Joseph A. Lepree, M.D., Elizabeth

Tuberculosis Council, State

John B. Fuhrmann, M.D., Flemington

Public Medical Care (Subcommittee of Council on Medical Services)

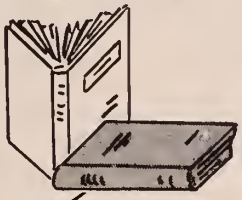
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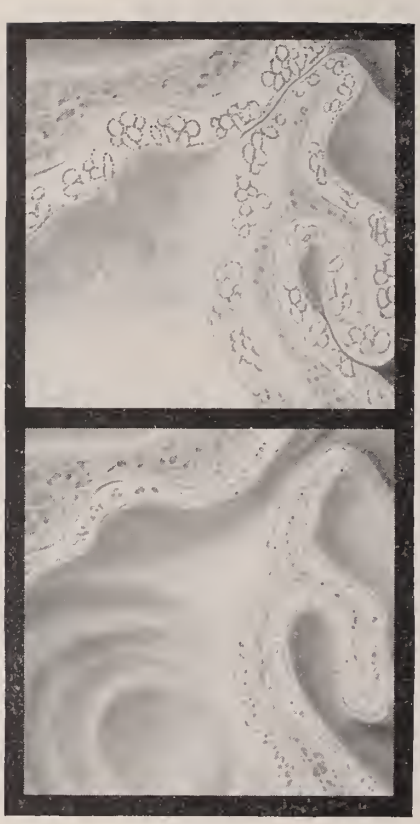
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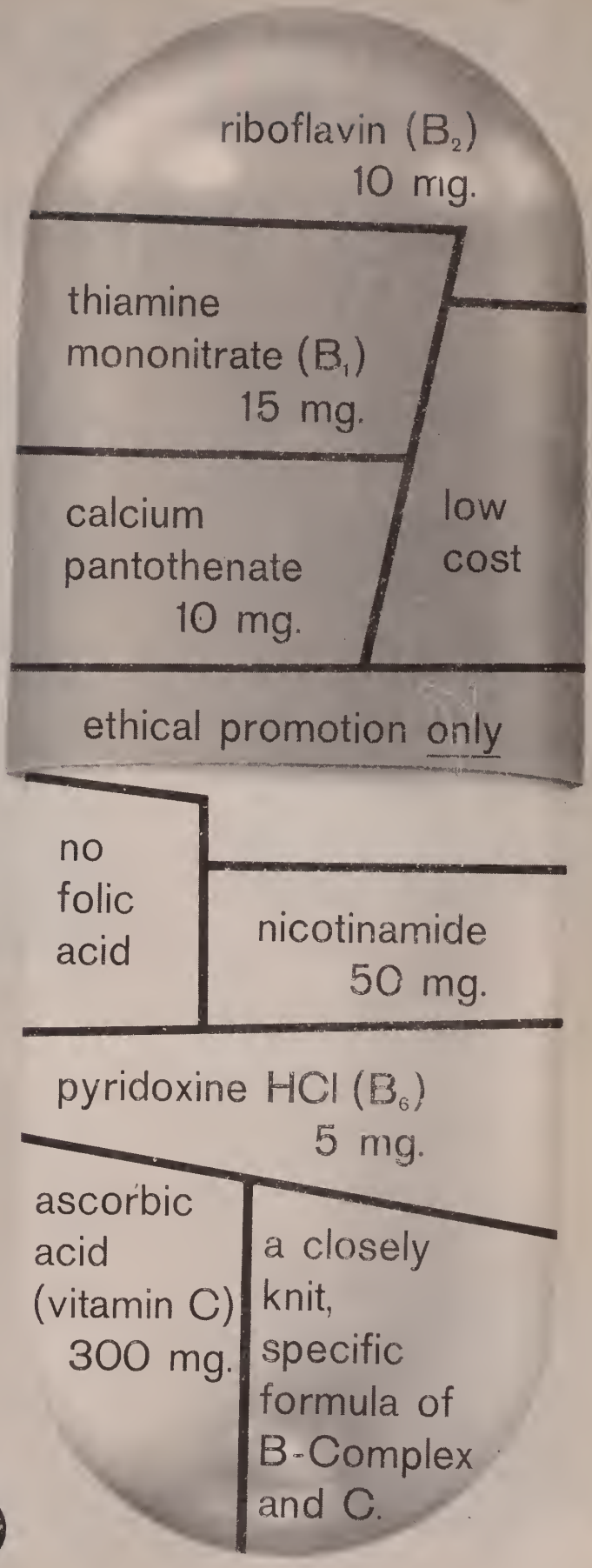
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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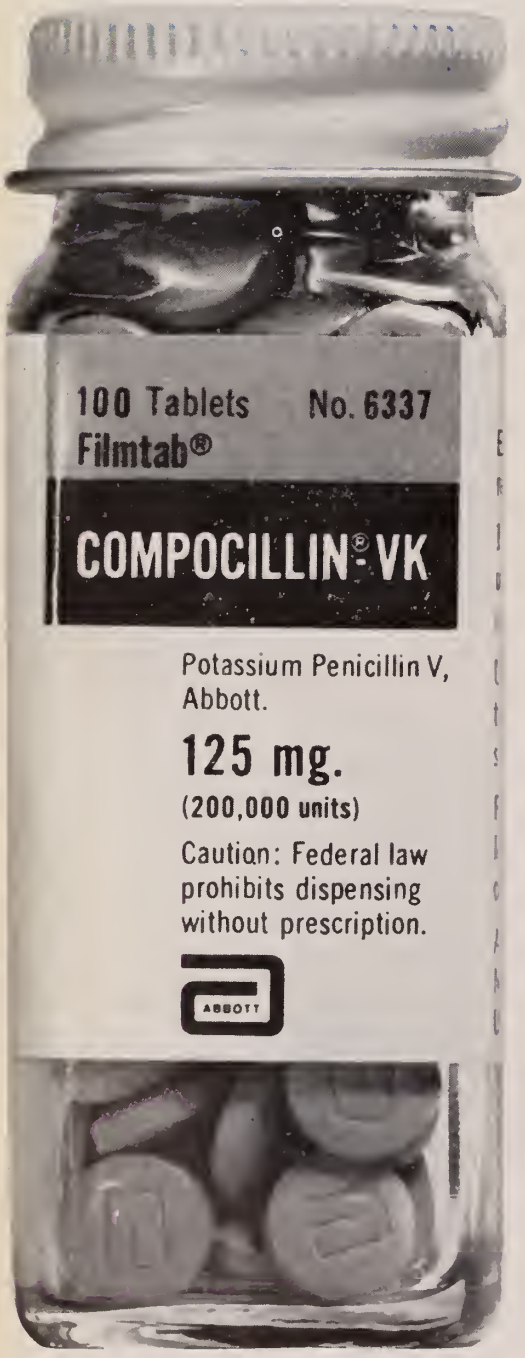
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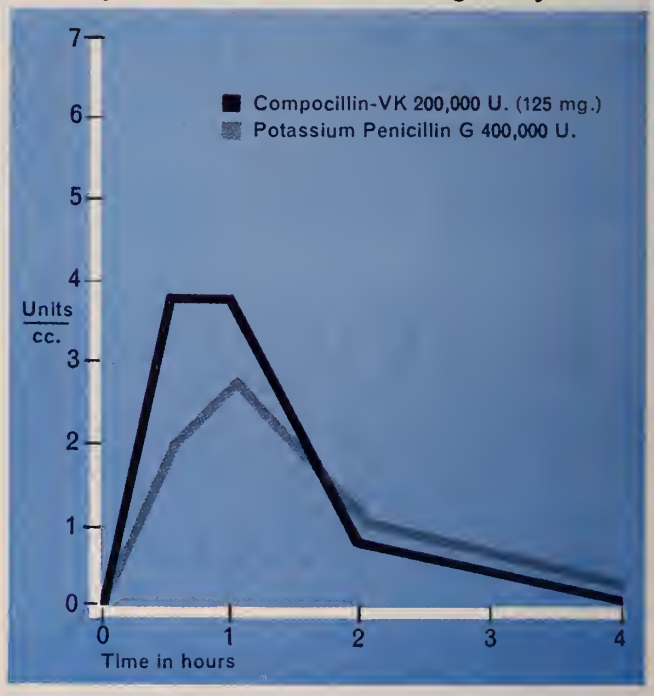
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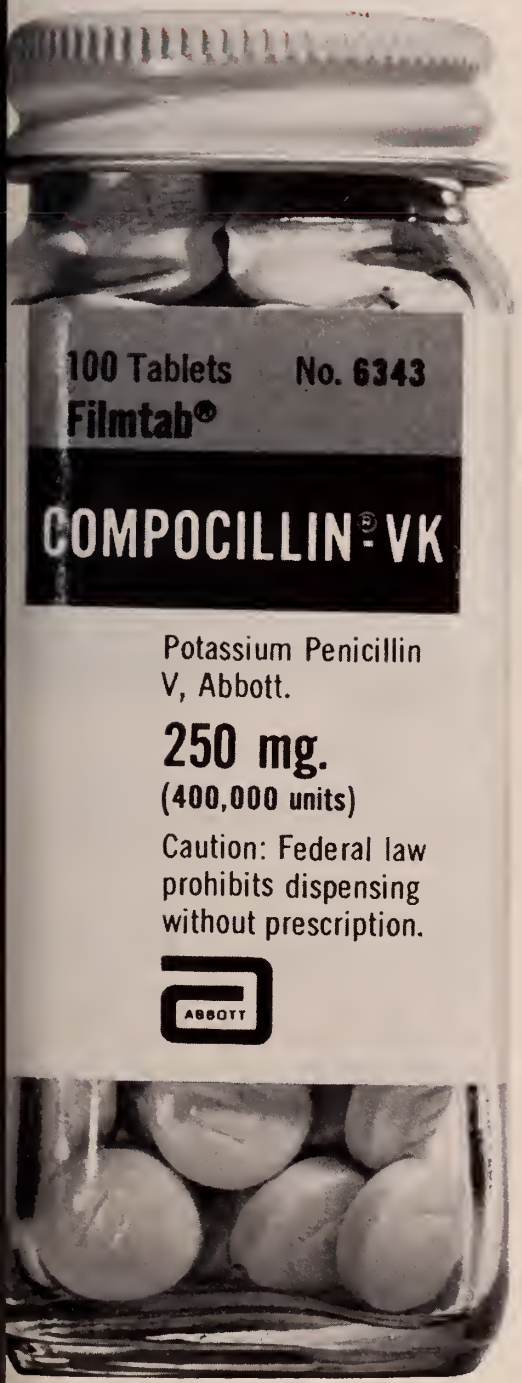
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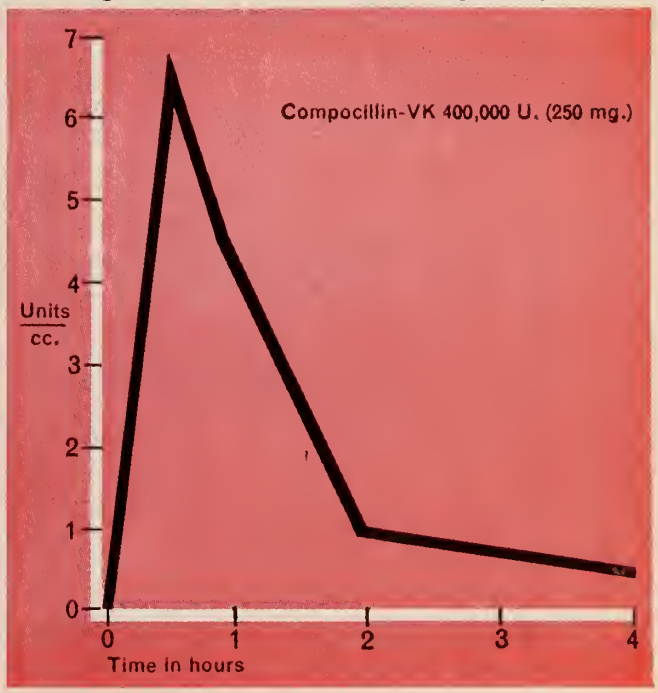
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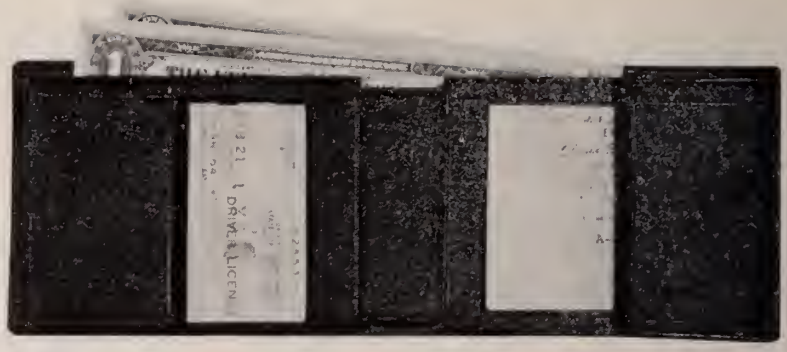


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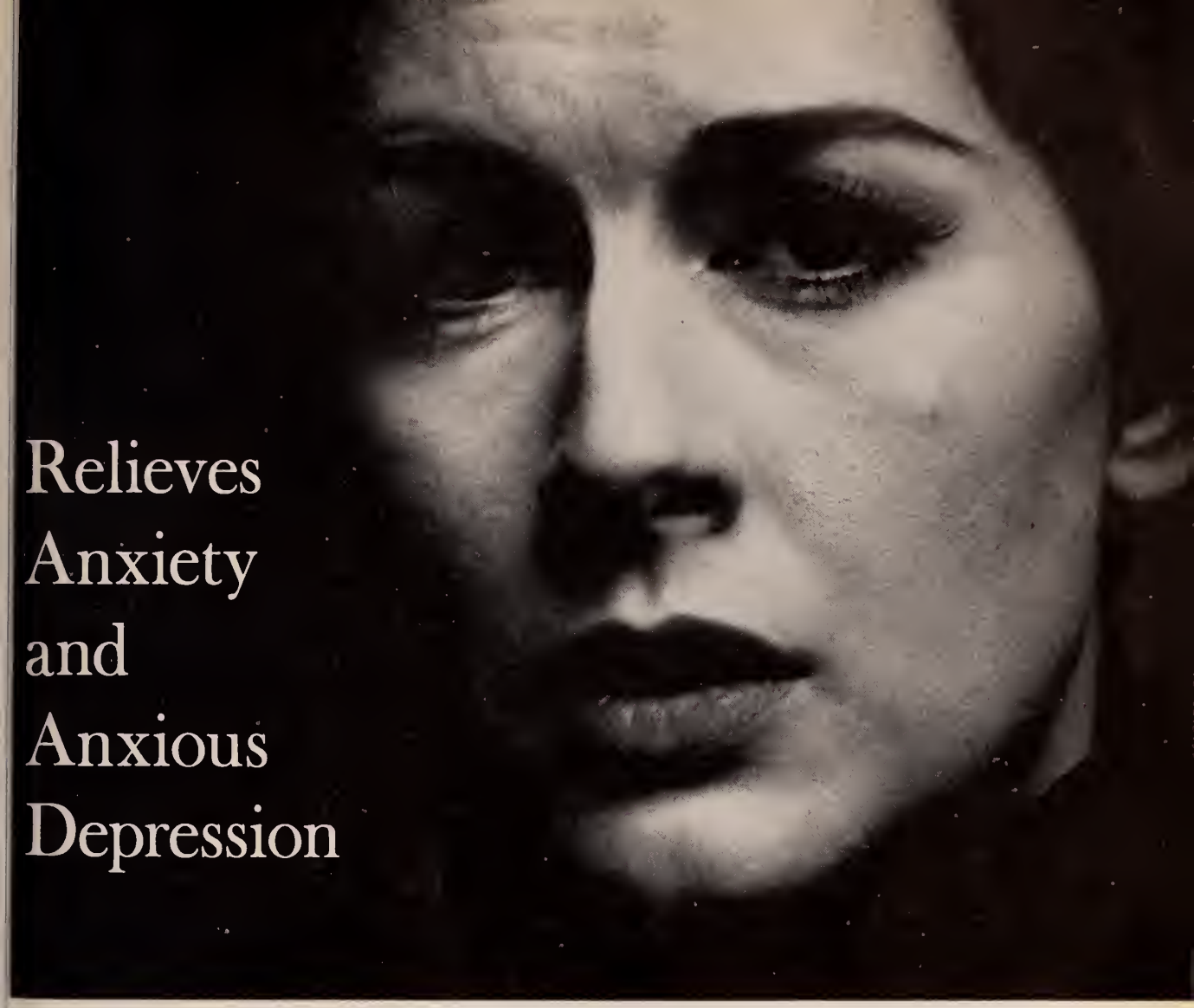
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WORLDWIDE COVERAGE.

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The plan does not cover expenses which are not reasonable or necessary or caused by or resulting from: the hazards of warfare; injury or sickness contracted while in the armed forces; suicide or attempt thereat; self-inflicted injury; injury or sickness covered by Workmen's Compensation or Occupational Disease Law; supplies or services which are furnished by or at the expense of the Federal Government or an agency thereof; treatment for alcoholism or narcotic addiction; or cosmetic surgery or congenital defects or air travel, except as specified in the policy.

TERMINATION:

As long as the Society's plan remains in force and you remain a member of the Society and pay the required premium, your insurance cannot terminate prior to age 70*. Similarly, dependent insurance continues concurrently with the member's policy as long as the person remains a Dependent as defined if premium is paid.

Full Details of Coverage Are in Policy

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DETROIT, MICHIGAN

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E. & W. BLANKSTEEN AGENCY, Inc.

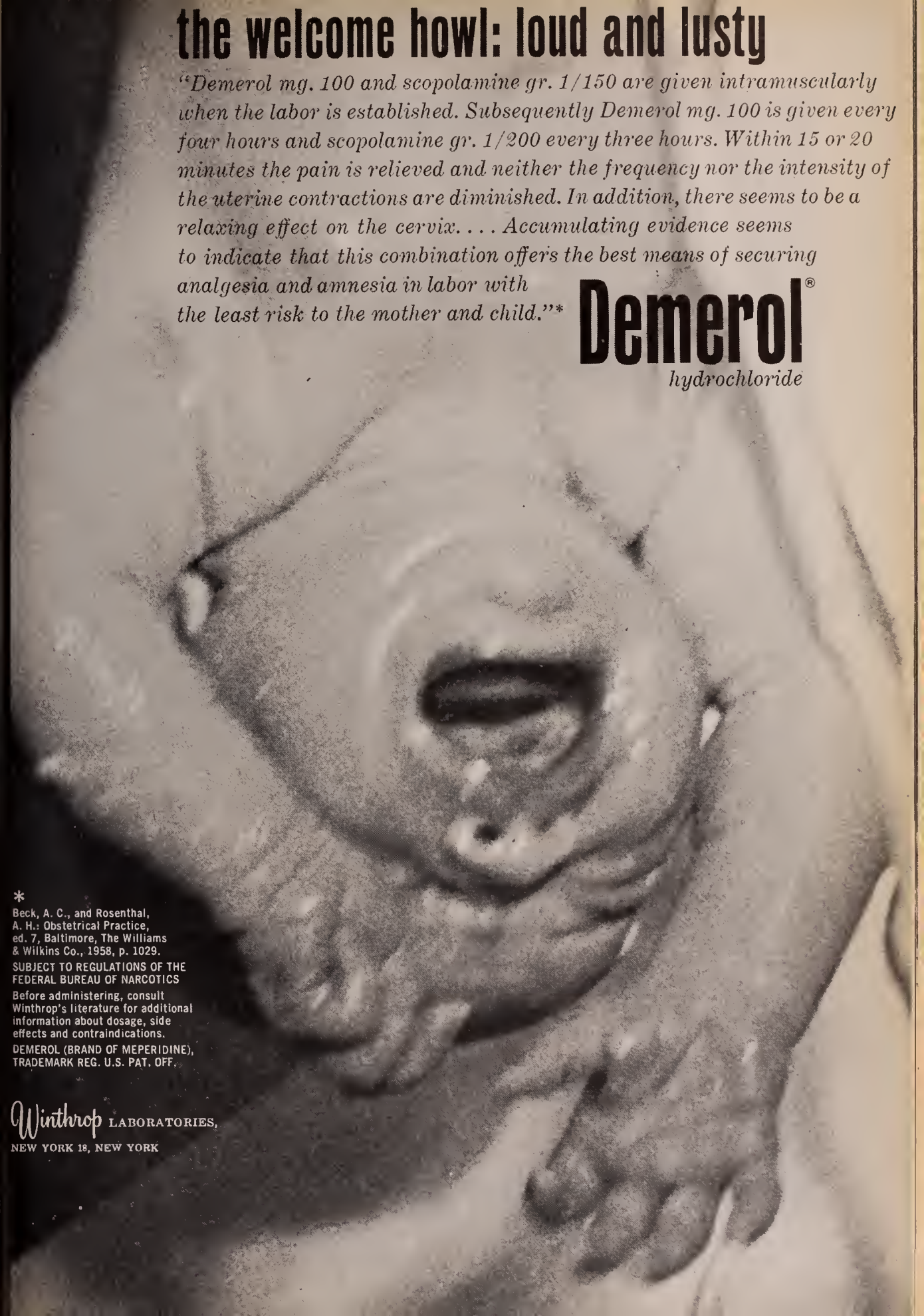
75 Montgomery St., Jersey City 2, N. J.

DElaware 3-4340

the welcome howl: loud and lusty

*"Demerol mg. 100 and scopolamine gr. 1/150 are given intramuscularly when the labor is established. Subsequently Demerol mg. 100 is given every four hours and scopolamine gr. 1/200 every three hours. Within 15 or 20 minutes the pain is relieved and neither the frequency nor the intensity of the uterine contractions are diminished. In addition, there seems to be a relaxing effect on the cervix. . . . Accumulating evidence seems to indicate that this combination offers the best means of securing analgesia and amnesia in labor with the least risk to the mother and child."**

Demerol®
hydrochloride



* Beck, A. C., and Rosenthal, A. H.: Obstetrical Practice, ed. 7, Baltimore, The Williams & Wilkins Co., 1958, p. 1029.

SUBJECT TO REGULATIONS OF THE FEDERAL BUREAU OF NARCOTICS

Before administering, consult Winthrop's literature for additional information about dosage, side effects and contraindications.

DEMEROL (BRAND OF MEPERIDINE), TRADEMARK REG. U.S. PAT. OFF.

Winthrop LABORATORIES,
NEW YORK 18, NEW YORK



Simon, F., & Bernstein, A.: The Treatment of Obesity in Patients with Cardiovascular Disease, Angiology, 32-37, Jan. '61. Plotz, M.: Modern Management of Obesity, J.A.M.A., 170:1513-1515 (July 25) 1959. Bernstein, A. & Simon, F.: Treatment of Obese Diabetics and Arteriosclerotics, Clin. Med., 907-920, May '61.

RELIEVE THE COLD SUPPRESS THE COUGH WITH NEW

'EMPRAZIL-C'

TABLETS

ANTITUSSIVE ▪ DECONGESTANT ▪ ANALGESIC

Each tablet contains:

Codeine Phosphate*	15 mg.
'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

*Warning—may be habit forming.

Complete literature available on request.

Also available without codeine as

'EMPRAZIL'®

TABLETS



BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

the right combination



. . . safe, effective antihypertensive therapy

Rauprote

(Rauwolfia serpentina and Protoveratrines A and B combined)

Rauprote combines two effective antihypertensive agents—*Rauwolfia serpentina* for moderate tranquillizing and gentle hypotensive effect, and Protoveratrines A and B for faster, more potent lowering of blood pressure and bradycrotic action. The combination produces a therapeutic hypotensive effect which is superior to larger doses of either drug alone; reduced dosage of both components minimizes or eliminates toxic side effects completely.[1,2]

Clinical studies show the majority of patients suffering from significant elevation of blood pressure achieve an excellent response to this combination.[2]

Rauprote is indicated in management of moderate to severe essential hypertension.

Supplied:
In bottles of 100 and 1,000 tablets, each tablet containing 50 mg. *Rauwolfia serpentina* and 0.2 mg. Protoveratrines A and B (alkaloids of *Veratrum album*).

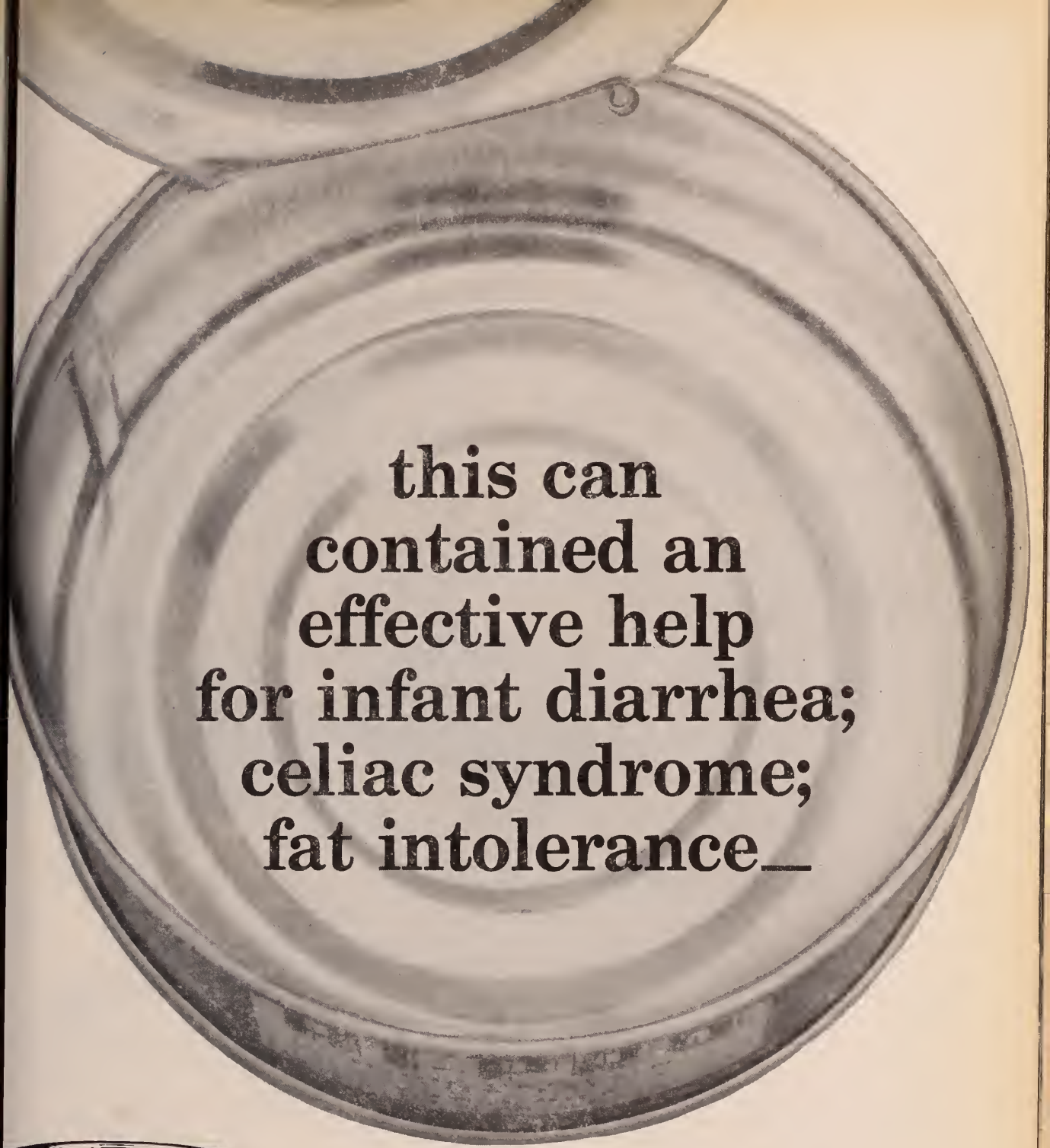
1. Goodman, L.S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., Macmillan & Co., New York (1955).

2. Roberts, E.: Four Year Evaluation of an Antihypertensive Agent, J. Am. Med. Women's Assn. *13*:349 (1958).

THE VALE CHEMICAL CO., INC.

VALE

Pharmaceuticals since 1922
Allentown, Pennsylvania



this can contained an effective help for infant diarrhea; celiac syndrome; fat intolerance_



Hi-Pro contains Protein 41%; Fat 14%; Lactose 35%. Available in 1-lb. and 2½-lb. cans.

AND IT'S FREE

SEND ME MY FREE SAMPLE OF HI-PRO, 2 OZ. SIZE

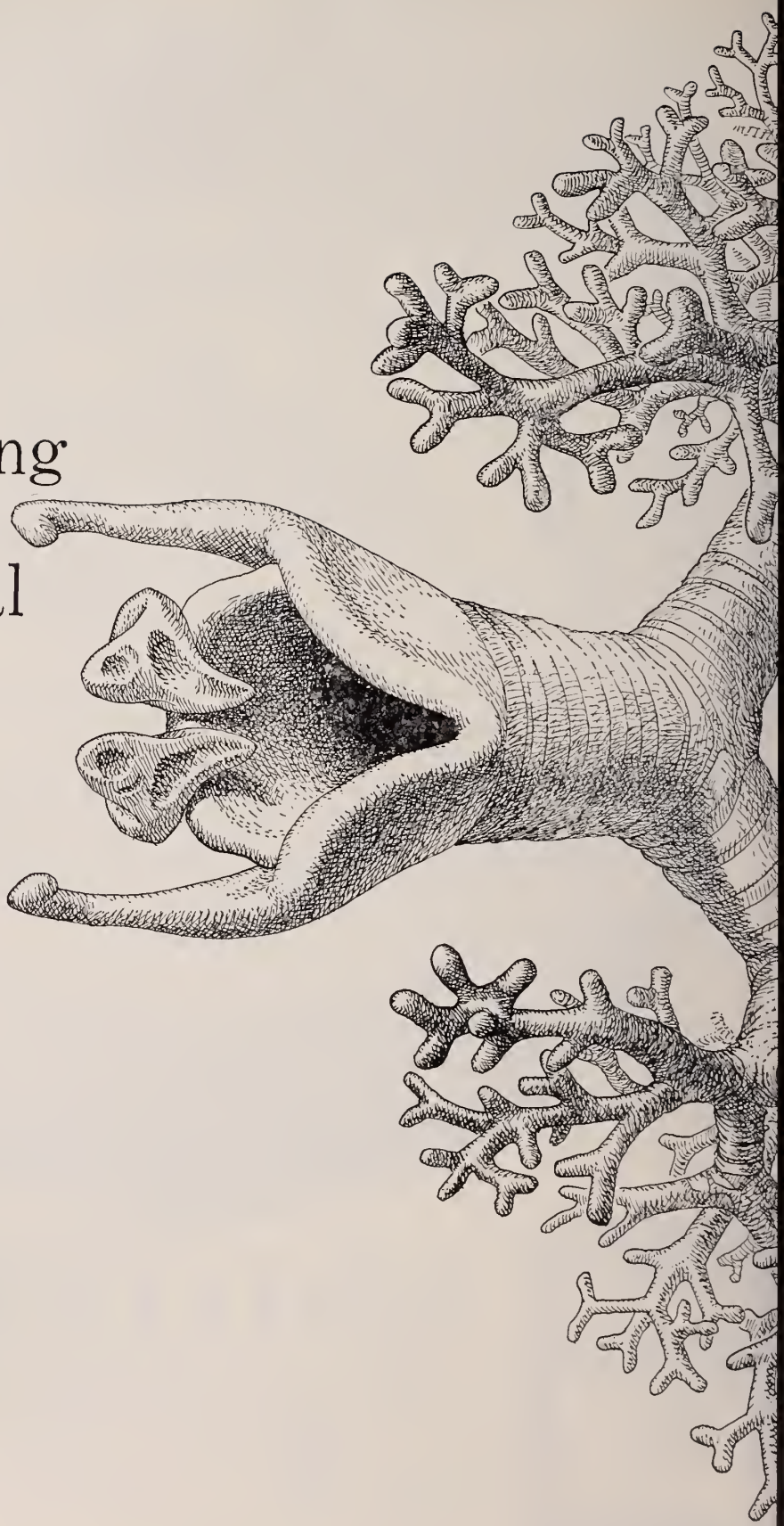
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Babying Americans since 1934

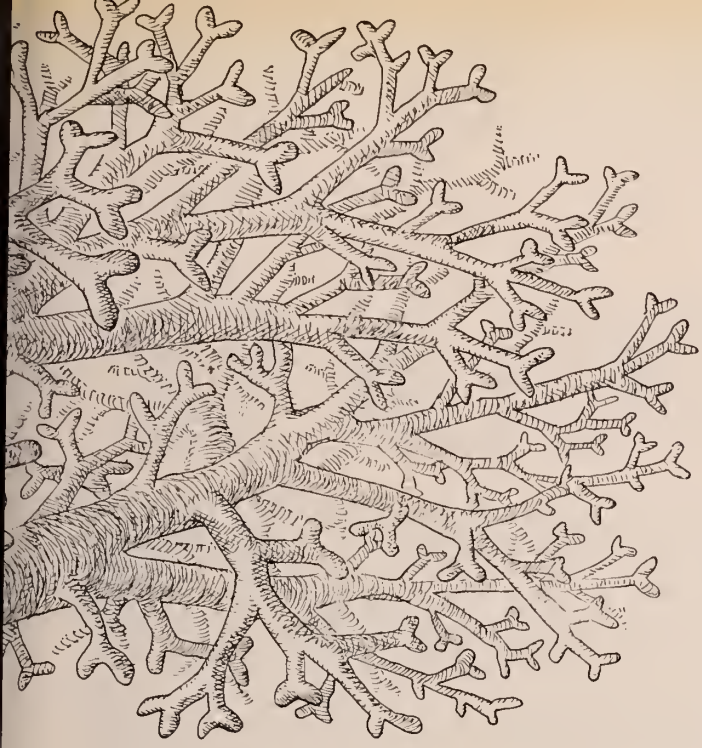
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gratifying
relief
in bronchial
asthma





unsurpassed for total patient benefits

Aristocort®

Triamcinolone Lederle



With ARISTOCORT, asthmatic patients obtain sustained relief of wheezing, dyspnea, and spasmodic coughing. It is of particular value in ameliorating severe attacks that may have serious sequelae. With ARISTOCORT, many patients who might otherwise be invalids are able to continue their customary livelihoods or maintain their regular household activities. Yet this symptomatic relief is not often accompanied by the hormonal collateral effects —sodium retention, edema, emotional disturbance, insomnia, voracious appetite— that so often have been a deterrent to steroid therapy.

SUPPLIED· Scored tablets (three strengths), syrup and parenteral. Request complete information on indications, dosage, precautions and contraindications from your Lederle representative, or write to Medical Advisory Department.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York

NEW **SPECIAL COUGH FORMULA**
for Children

Pediacof

Trademark

SOOTHING DECONGESTANT AND EXPECTORANT

Each teaspoon (5 cc.) contains:

Codeine phosphate	5.0 mg.
Neo-Synephrine® hydrochloride (brand of phenylephrine hydrochloride)	2.5 mg.
Chlorpheniramine maleate	0.75 mg.
Potassium iodide	75.0 mg.



Bright red, pleasant tasting, raspberry flavored syrup

Dosage:

Children from 6 months to 1 year, 1/4 teaspoon; 1 to 3 years, 1/2 to 1 teaspoon; 3 to 6 years, 1 to 2 teaspoons; 6 to 12 years, 2 teaspoons. Every four to six hours as needed.

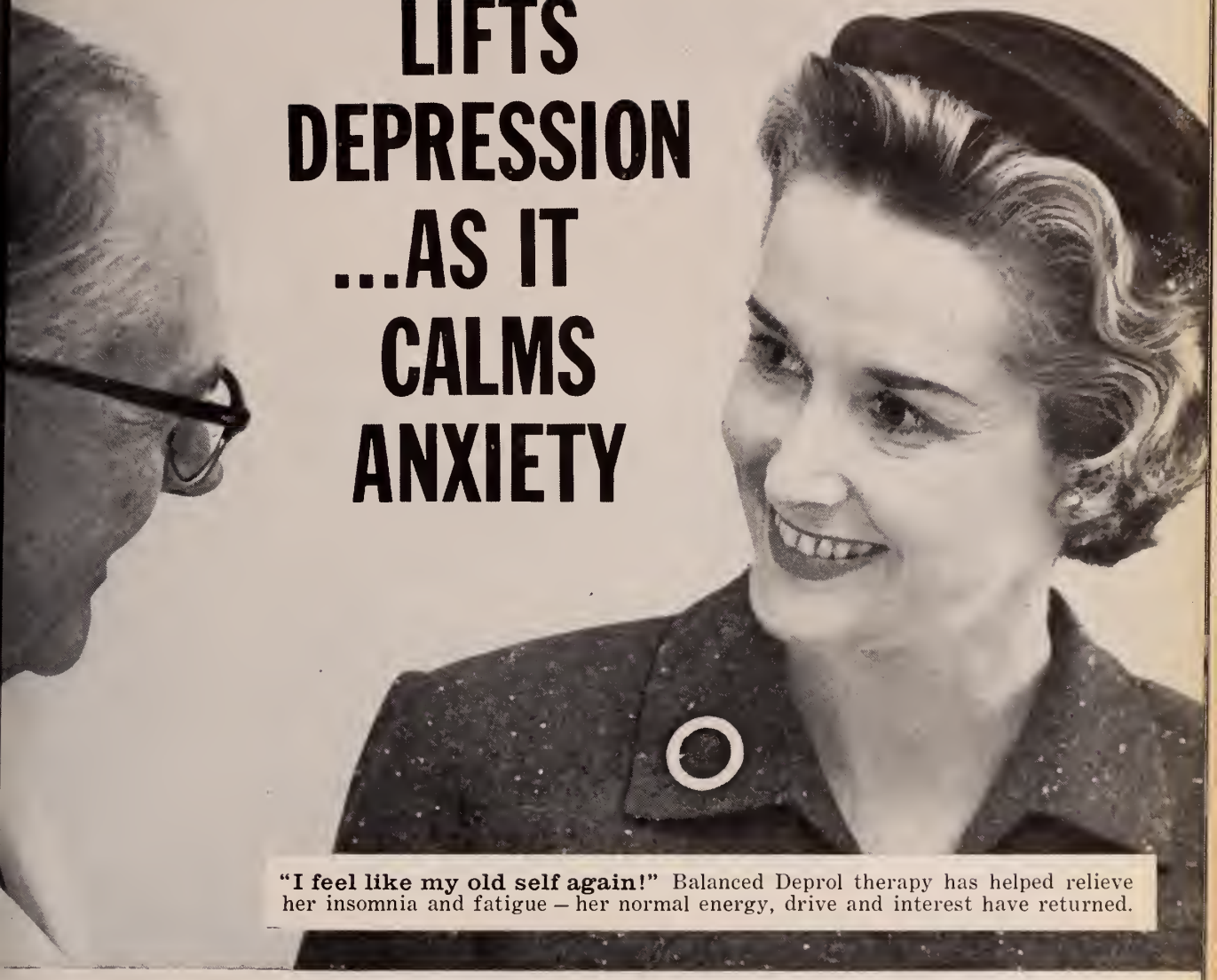
How Supplied:
Bottles of 16 fl. oz.

Exempt Narcotic

Winthrop
LABORATORIES
New York 18, N. Y.

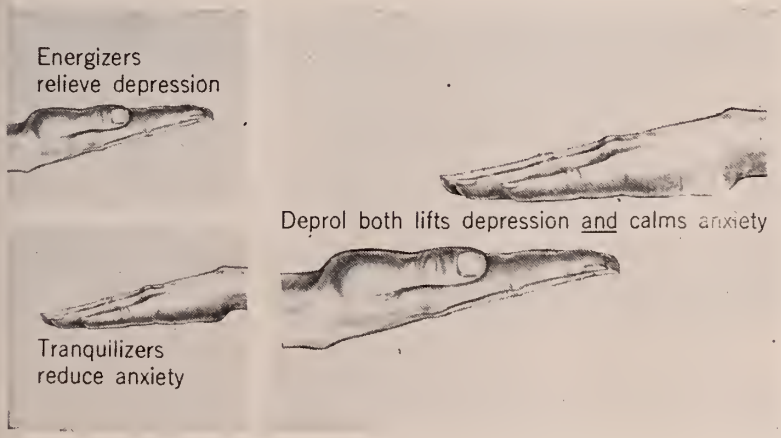
Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

LIFTS DEPRESSION ...AS IT CALMS ANXIETY



"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

Brightens mood...relaxes tension



Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

▲Deprol▲®

WALLACE LABORATORIES
Cranbury, N.J.

CD-7393

When you choose an anorectic—

"Does it help the patient maintain the proper diet, is it free of dangerous side effects, and does the patient like it?"[1]

Perhaps you'll find, as Stevenson did, "['Eskatrol'] seems to meet these criteria better than most."

1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



ESKATROL®
SPANSULE®

brand of sustained release capsules

PRESCRIBING INFORMATION

Formula: Each 'Eskatrol' *Spansule* sustained release capsule contains Dexedrine® (brand of dextro amphetamine sulfate), 15 mg., and Compazine® (brand of prochlorperazine), 7.5 mg., as the dimaleate.

Recommended Dosage: One 'Eskatrol' *Spansule* capsule daily, taken in the morning.

Side Effects: Side effects (chiefly nervousness and insomnia) are infrequent, and usually mild and transitory.

Cautions: Clinical experience has demonstrated that 'Eskatrol' (containing the phenothiazine derivative, prochlorperazine) has a wide margin of safety and that there is little likelihood of blood or liver toxicity or neuromuscular reactions (extrapyramidal symptoms). The physician should be aware, however, of their possible occurrence.

'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability.

Prescribing information adopted Jan. 1961

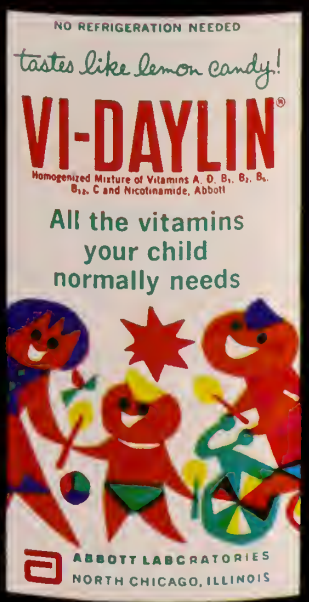
Smith Kline & French Laboratories SK&F



How do the lemons get in the Vi-Daylin?

Perhaps this should be cleared up once and for all. There are *no* lemons in Vi-Daylin. If you've ever tasted Vi-Daylin, this might surprise you. Certainly, it would surprise the youngsters. To most of them, Vi-Daylin is liquid lemon candy, and that's *that*. But if it's deception, it's sensible deception. You never have to badger the kids into taking their vitamins. Nice to know, too, that this matchless matching of candy essence and color elegance can be found in all the forms and formulas of Vi-Daylin.

VI-DAYLIN—Vitamins A, D, B_1, B_2, B_6, B_{12}, C, and Nicotinamide, Abbott; VIDAYLIN-M—Homogenized Mixture of Vitamins with Minerals, Abbott; VI-DAYLIN-T—High Potency Multivitamins, Abbott.



Remember, there are *three* liquid formulas: Vi-Daylin, ViDaylin-M® (with minerals), and ViDaylin-T® (therapeutic). And if patients get a little owlly and won't touch *anything* in a spoon, you can give them the new Chewable (please see back of this page).

Each delicious, 5-cc. teaspoonful of Vi-Daylin supplies the following proportions of the Minimum Daily Requirements of:

		MDR (Children)	MDR (Infants)
Vitamin A	0.9 mg. (3000 units)	1	2
Vitamin D	10 mcg. (400 units)	1	1
Thiamine HCl (B_1)	1.5 mg.	2	6
Riboflavin (B_2)	1.2 mg.	1⅓	2
Ascorbic Acid (C)	50 mg.	2½	5
Nicotinamide	10 mg.	1⅓	2

Also supplies cyanocobalamin (B_{12}) 3 mcg. and pyridoxine Hydrochloride 1 mg.

209CJ84A

Abbott Laboratories
North Chicago, Illinois

Gentlemen,

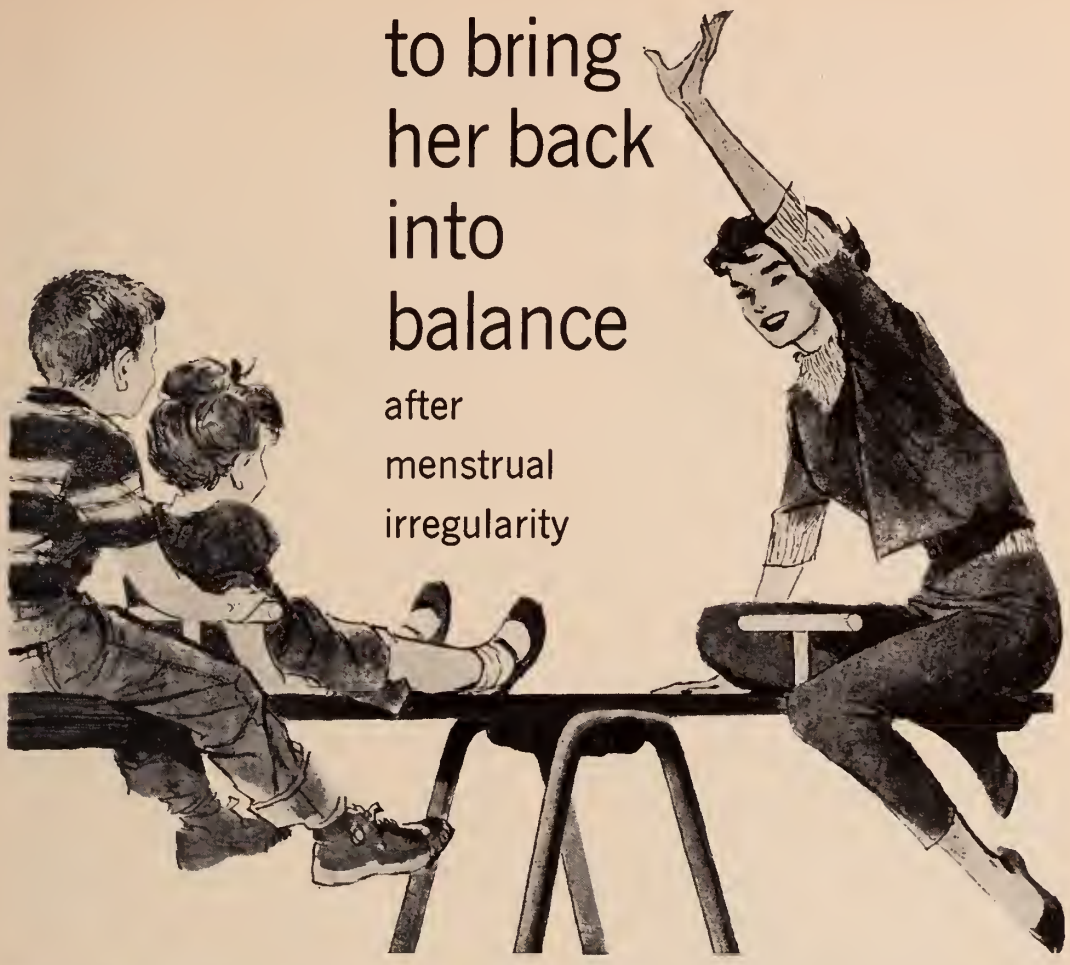
My family enjoys your chewable vitimans. It seems like we can not get enough of your vitimans. My sister enjoys your vitimans so much that she ask for more but cannot have no more. I like them because my mother does not have to worry about scolding us when taking it. Its good because you don't have no worries about something falling on the floor. If you kept on making these vitimans all the worlds children would be happy again. Now I would like to know whether I may have any information on the Middle West. You see my class and I are studying it. So if the information can be given I thank you very much.

"...all the worlds children would be happy again."

(an unsolicited testimonial from an actual letter)



ABBOTT



to bring her back into balance

after menstrual irregularity

an orally active progestogen-estrogen combination

Duosterone®

anhydrohydroxyprogesterone . . . 10.00 mg.
ethinyl estradiol . . . 0.01 mg. } per tablet

Supplementing and supporting ovarian function, DUOSTERONE tablets can help release your patients from the anxiety, discomfort and inconvenience of functional amenorrhea and dysfunctional uterine bleeding.

DUOSTERONE therapy simulates and enhances the normal hormonal pattern of the secretory phase of the menstrual cycle, providing orally potent progesterone with ethinyl estradiol to prime the endometrium for adequate progestational response. Periodic progestational treatment with DUOSTERONE tablets aims at restoring the normal menstrual cycle—much as touching the pendulum starts a tightly wound clock.

Based on the classic studies of Zondek, Rakoff and others, DUOSTERONE provides dependable, trouble-free progestational therapy by mouth.

Bottles of 25 and 100 tablets with complete dosage instructions.

ROUSSEL

Roussel Corporation, New York 17, N.Y.

asthma attack averted
. . . in minutes

patient protected
. . . for hours





Nephenalin®

(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

Dosage: Hold one NEPHENALIN tablet under the tongue for five minutes to abort the asthmatic attack promptly. Then swallow the tablet core for four full hours' protection against further attack. Only one tablet should be taken every four hours. No more than five tablets in 24 hours.

Supplied: Bottles of 50 tablets. For children: NEPHENALIN Pediatric, bottles of 50 tablets.

Caution: Do not administer NEPHENALIN with epinephrine. The two medications may be alternated at 4-hour intervals. NEPHENALIN should be administered with caution to patients with hyperthyroidism, acute coronary disease, cardiac asthma, limited cardiac reserve, acute myocardial damage, and to those hypersensitive to sympathomimetic amines. Phenobarbital may be habit forming. THOS. LEEMING & CO., INC., New York 17, N.Y.

INDICATION: *Accidental trauma*



INDICATED:
Chymoral®

cuts healing time in accidental trauma

Whether the patient presents the simple edema and inflammation of a sprained ankle or the severe lacerations and bruising from a violent accident, immediate adjunctive use of Chymoral speeds resolution of traumatic manifestations. Chymoral modifies the inflammatory reaction to trauma, dissipates edema and blood extravasates, improves regional circulation, and thus aids the body's natural reparative activities. In other general practice areas, too, Chymoral cuts healing time. Excellent results have been achieved in acute sinusitis, bronchitis, bronchial asthma, emphysema, chronic pelvic inflammatory disease, and acute thrombophlebitis.[1-5]

Controls inflammation,
curtails swelling, curbs pain

1. Beck, C., *et al.*: Clin. Med. 7:519, 1960. 2. Teitel, L. H., *et al.*: Indust. Med. 29:150, 1960. 3. Billow, B. W., *et al.*: Southwestern Med. 41:286, 1960. 4. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 5. Taub, S. J.: Clin. Med. 7: 2575, 1960.

ARMOUR PHARMACEUTICAL COMPANY
KANKAKEE, ILLINOIS
Originators of Listica®

CHYMORAL

Chymoral is an ORAL anti-inflammatory enzyme tablet specifically formulated for intestinal absorption. Each tablet provides enzymatic activity, equivalent to 50,000 Armour Units, supplied by a purified concentrate which has specific trypsin and chymotrypsin activity in a ratio of approximately six to one. ACTION: Reduces inflammation of all types; reduces and prevents edema except that of cardiac or renal origin; hastens absorption of blood and lymph extravasates; helps to liquefy thick tenacious mucous secretions; improves regional circulation; promotes healing; reduces pain. INDICATIONS: Chymoral is indicated in respiratory conditions such as asthma, bronchitis, rhinitis, sinusitis; in accidental trauma to speed absorption of hematoma, bruises, and contusions; in inflammatory dermatoses to ameliorate acute inflammation in conjunction with standard therapies; in gynecologic conditions such as pelvic inflammatory disease and mastitis; in obstetrics as episiotomies and breast engorgement; in surgical procedures as biopsies, hernia repairs, hemorrhoidectomies, mammectomies, phlebitis and thrombophlebitis; in genitourinary disorders as epididymitis, orchitis and prostatitis; in dental and oral surgery as fractures of the mandible or maxilla, difficult or multiple extractions, and alveolectomies. CONTRAINDICATIONS: None known. INCOMPATIBILITIES: None known. Antibiotics as well as generally accepted measures may be coadministered. SIDE EFFECTS: Mild gastric upsets, rarely encountered. DOSAGE: Recommended initial dose is two tablets q.i.d.; one tablet q.i.d. for maintenance. SUPPLIED: Bottles of 48 and 250 tablets.

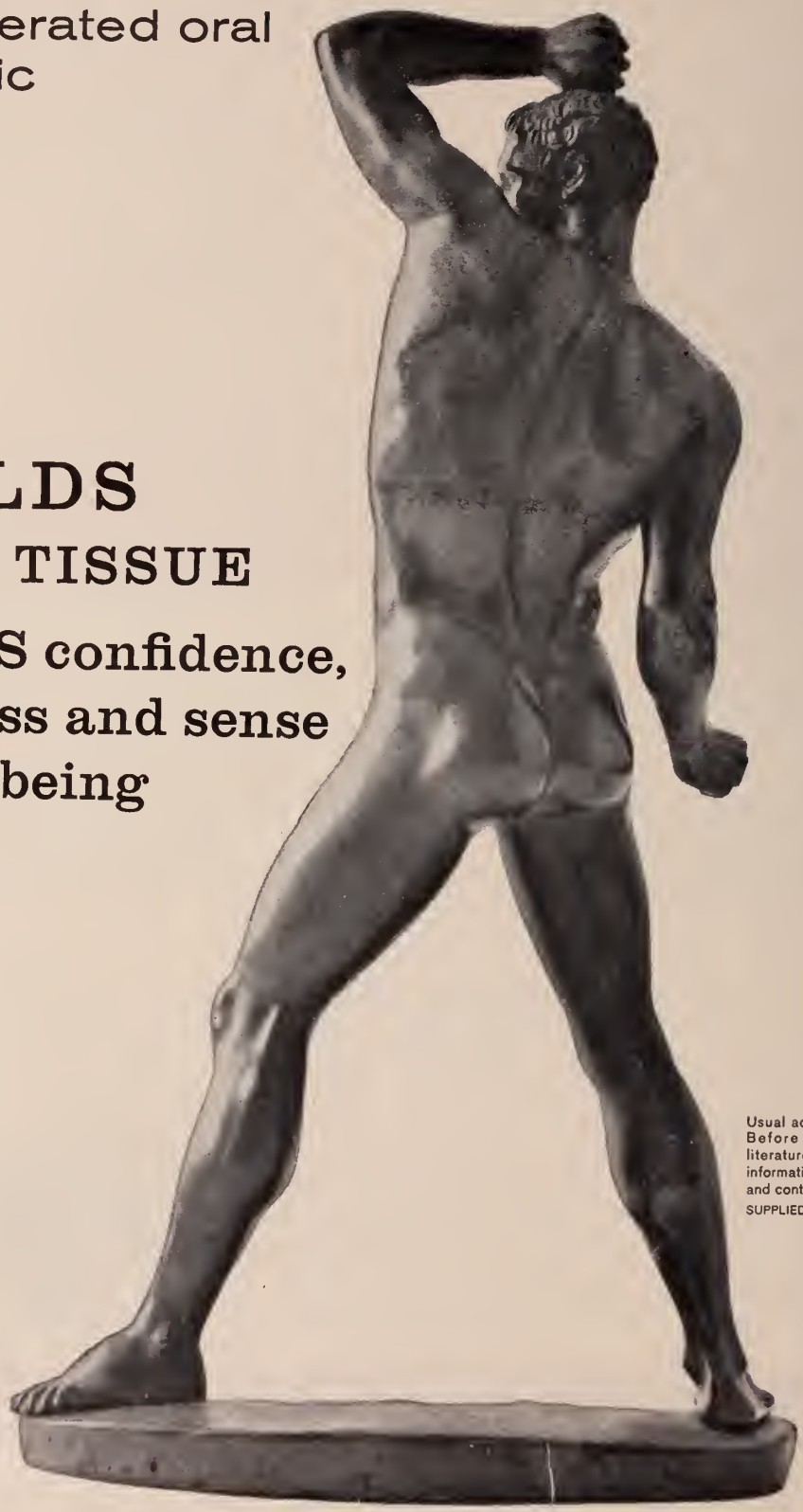
CHYMORAL *ORAL systemic anti-inflammatory enzyme tablet*

THE SIGNIFICANT NEW PHYSIOTONIC

WINSTROL®

BRAND OF STANOZOLOL

well tolerated oral anabolic



BUILDS BODY TISSUE

BUILDS confidence, alertness and sense of well-being

Usual adult dose: 1 tablet t.i.d. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

SUPPLIED: 2 mg. tablets. Bottles of 100.

Winthrop
LABORATORIES
New York 18, N.Y.

With WINSTROL, patients look better... feel stronger—because they are stronger



Put your low-back patient back on the payroll

Soma relieves stiffness –stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, fast!

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

Kestler reports in controlled study: *Average time for restoring patients to full activity: with Soma, 11.5 days; without Soma, 41 days. (J.A. M.A. Vol. 172, No. 18, April 30, 1960.)*

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets. USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving act

SOMA

(carisoprodol, Walla

Wallace Laboratories, Cranbury, New Jers



FILMTAB®

SURBEX-T® provides therapeutic B-complex with 500 mg. of C



Patients receive replenishment in the easiest possible manner when the water soluble vitamins are depleted, or demands are increased.

Each Filmtab® Surbex-T represents:

Thiamine Mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Nicotinamide	100 mg.
Pyridoxine Hydrochloride	5 mg.
Cobalamin (Vitamin B_{12})	4 mcg.
Calcium Pantothenate (as calcium pantothenate racemic)	20 mg.
Ascorbic Acid (C) (as sodium ascorbate)	500 mg.
Desiccated Liver, N.F.	75 mg.
Liver Fraction 2, N.F.	75 mg.

...and when needs are more moderate, SUR-BEX® with C, Abbott's improved B-complex formula with 250 mg. of C.

ABBOTT

210270

Filmtab—Film-sealed tablets, Abbott: U.S. Pat. No. 2,881,085



Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

LONG TERM AUTO LEASING

Lease a brand new Cadillac or other fine car from American and you'll never **buy** again. Save money, time and trouble. One modest monthly payment takes care of everything . . . insurance, maintenance, repairs, depreciation . . . and the payments are 100% tax deductible! Borrow a car—free of charge—in case of accident or breakdown.

. . . A SERVICE ESPECIALLY PLANNED FOR DOCTORS!

M.D. PLATES FREE, TOO!

Special!

BRAND NEW 1962 2-DOOR HARDTOP CHEVROLET

IMPALA

INCLUDES

- Registration and plates
- Full maintenance
- Insurance
  - Liability $250/$500,000
  - Property damage $20,000
  - Deductible collision, fire and theft

ALL YOU BUY IS GAS AND OIL



ASK FOR BROCHURE

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AMERICAN AUTO LEASING COMPANY

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ENTOZYME® helps your gallbladder patient digest fat

The gallbladder patient who "can't resist" rich, succulent, greasy foods must often pay for his gastronomical indiscretions with the discomforts of fat-induced indigestion. However, these unpleasant aftereffects can frequently be relieved or prevented with Entozyme, a natural digestive supplement. Six tablets, the usual daily dose, will digest 60 gm. of fat or more. That's 50 to 90 per cent of an adult's normal daily intake. Bile salts stimulate the flow of bile and enhance the lipolytic activity both of Entozyme's Pancreatin and the patient's own lipase. Working together, Bile Salts and Pancreatin greatly aid the emulsification and transport of fat. Each enteric-coated Entozyme tablet contains Bile Salts (150 mg.) and Pancreatin, N.F. (300 mg.). Also 250 mg. of Pepsin, N.F.—enough to digest 8 gm. of protein.

A. H. Robins Company, Inc., Richmond 20, Virginia



from boutonneuse fever in Africa

Whether treating boutonneuse fever, bronchopneumonia, or a host of other infections, physicians throughout the world continue to rely on the effectiveness, relative safety, and exceptional toleration of Terramycin in broad-spectrum antibiotic therapy. This continuing confidence is based upon thousands of published clinical reports and successful experience in millions of patients. *The next infection you see will more than likely be "Terra-responsive."*



IN BRIEF The dependability of Terramycin in daily practice is based upon its broad range of antimicrobial effectiveness, excellent toleration, and low toxicity. As with other broad-spectrum antibiotics, overgrowth of nonsusceptible organisms may develop. If this occurs, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing. Glossitis and allergic reactions to Terramycin are rare. For complete information on Terramycin dosage, administration, and precautions, consult package insert before using.

More detailed professional information available on request.

Boutonneuse fever is a tick-borne, acute, febrile disease often affecting children. The bite site becomes a small, necrotic ulcer. A striking macular or maculopapular eruption develops on the trunk, palms and soles. Onset is sudden, with chills, high fever, violent headache and lassitude. The high temperature—up to 103° F.—characteristic of both boutonneuse fever and bronchopneumonia, drops rapidly following initiation of Terramycin therapy.

to bronchopneumonia in New Jersey

BRAND OF OXYTETRACYCLINE

Terramycin® capsules • syrup • pediatric drops
intramuscular solution • intravenous

also available with nystatin as TERRASTATIN® (capsules and oral suspension)



NEW PORTABLE CAMBRIDGE EXTERNAL DEFIBRILLATOR

SIMPLIFIES
SPEEDS
STANDARDIZES
CARDIAC
RESUSCITATION

The design of the Cambridge Defibrillator emphasizes reliability, convenience and speed of operation—since time and reliability are of utmost importance. Based on latest medical findings, the Cambridge Defibrillator represents an important development in cardiac resuscitation. Fully portable, it offers many new operational features.

The Cambridge Defibrillator is operated by *one* person. It *eliminates* voltage estimating by providing two fixed settings—one for an adult, the other for a child. An *automatic* timing device assures the correct duration of the shock. A thumb button positioned on the right electrode—where it can be used most naturally and effectively—assures absolute control.

Exclusive circuit tester gives positive assurance that the instrument is in "go" condition. A reset control removes any chance of an accidental second shock. The comfortable "grip" electrode handles are non-conductive and are positioned to enable quick and positive electrode contact with the patient.

No operating room, intensive care unit, or recovery room can now be considered complete without a Cambridge External Defibrillator.

Examine and test the Cambridge Defibrillator, Doctor, and see how simple, uncomplicated and uncluttered an effective Defibrillator can be . . . and inexpensive, too! A demonstration of this new, complete instrument will be gladly given—just phone your nearest representative.



EASILY PORTABLE—SELF CONTAINED UNIT. Weighs only 26 lbs. Even the smallest nurse can carry it. All components are contained within a sturdy, compact aluminum case—no accessories to forget or lose.

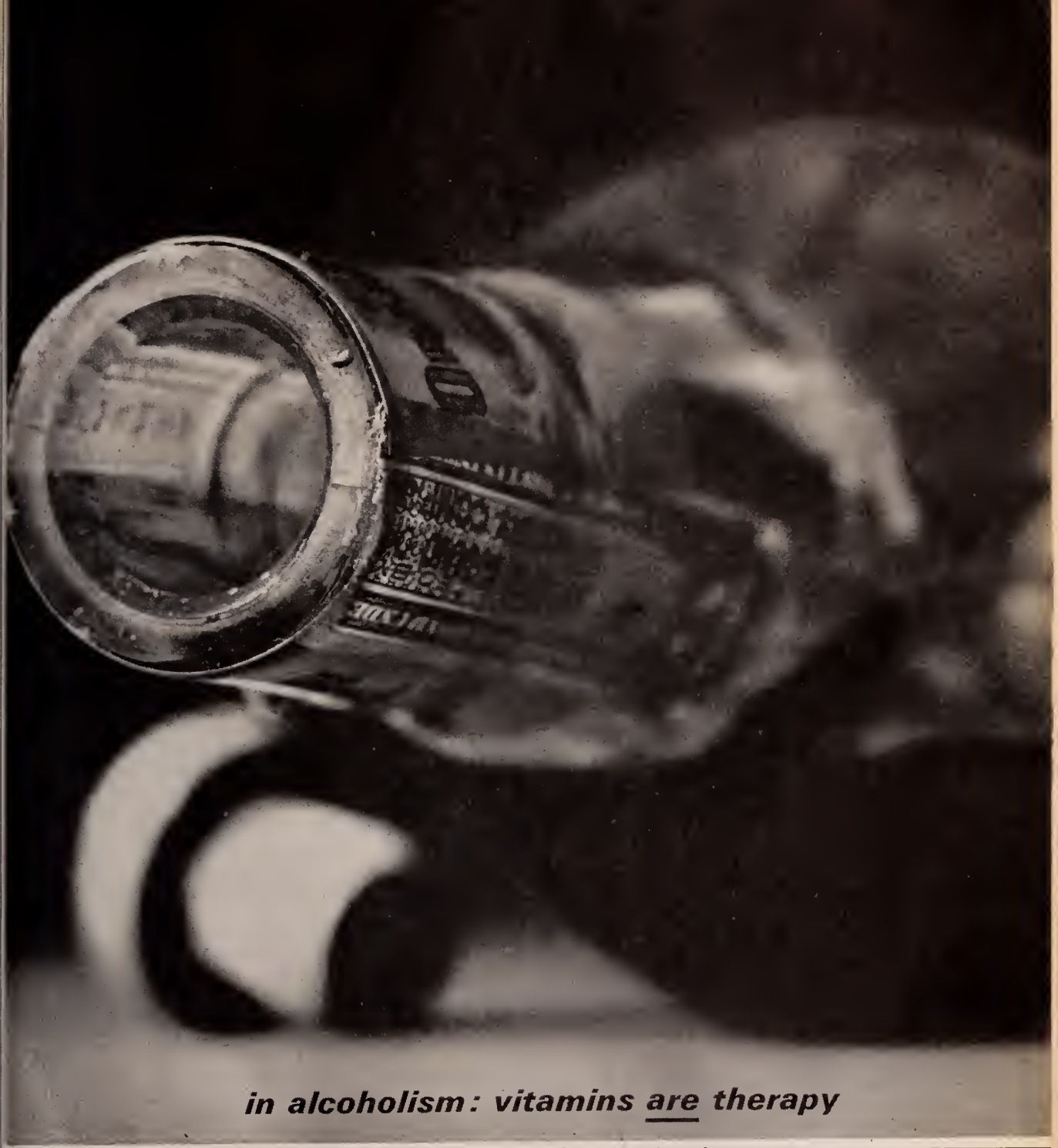
BUILT-IN THUMB CONTROL. Right under the doctor's thumb on the electrode handle—where he can press it naturally, firmly and at the right instant.



Send for Bulletin 480

CAMBRIDGE INSTRUMENT COMPANY, INC.

GRAYBAR BLDG., 420 LEXINGTON AVE., N. Y. 17, N. Y.



in alcoholism: vitamins are therapy

A full "comeback" for the alcoholic is partly dependent on nutritional balance...aided by therapeutic allowances of B and C vitamins. Typically, the alcoholic patient is seriously undernourished...from long-standing dietary inadequacy, from depletion of basic reserves of water-soluble vitamins. Supplied in decorative "reminder" jars of 30 and 100.

Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 m
Vitamin B_2 (Riboflavin)	10 m
Niacinamide	100 m
Vitamin C (Ascorbic Acid)	300 m
Vitamin B_6 (Pyridoxine HCl)	2 m
Vitamin B_{12} Crystalline	4 mcg
Calcium Pantothenate	20 m

Recommended intake: Adults, 1 capsule dai or as directed by physician, for the treatme of vitamin deficiencies.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

STRESSCAPS®

Stress Formula Vitamins Lederle

PROFESSIONAL LIABILITY INSURANCE PROGRAM

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

PROTECTION for Professional Acts and Professional Premises Liability for members of The Medical Society of New Jersey by the First American Liability Insurance Company.

LOSS CONTROL. Your County Medical Review and Advisory Committee will evaluate malpractice cases and recommend the action which would be most favorable for the Medical Profession, the Defendant Doctor, the Patient and the Public. This program permits understanding of the complex problems involved in such cases and calls for close cooperation between the Medical Profession and Insurance Company.

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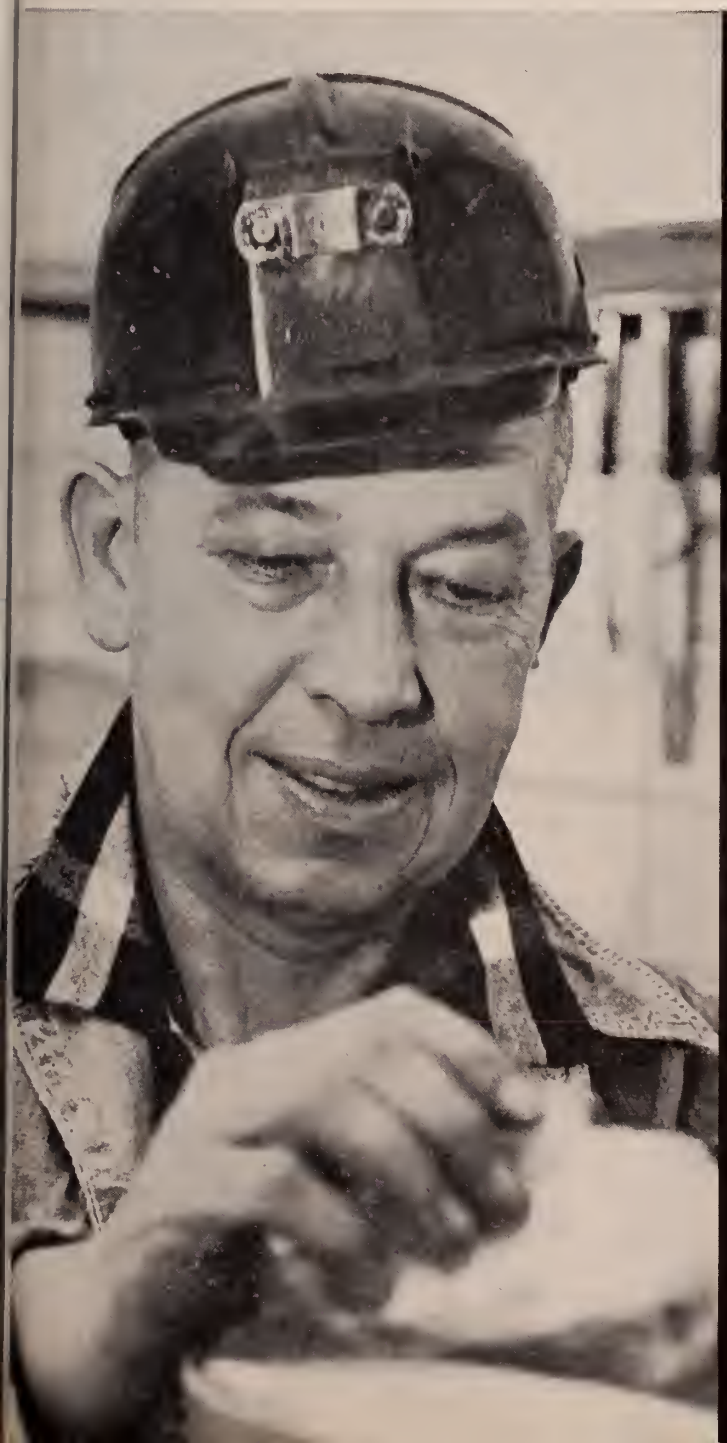
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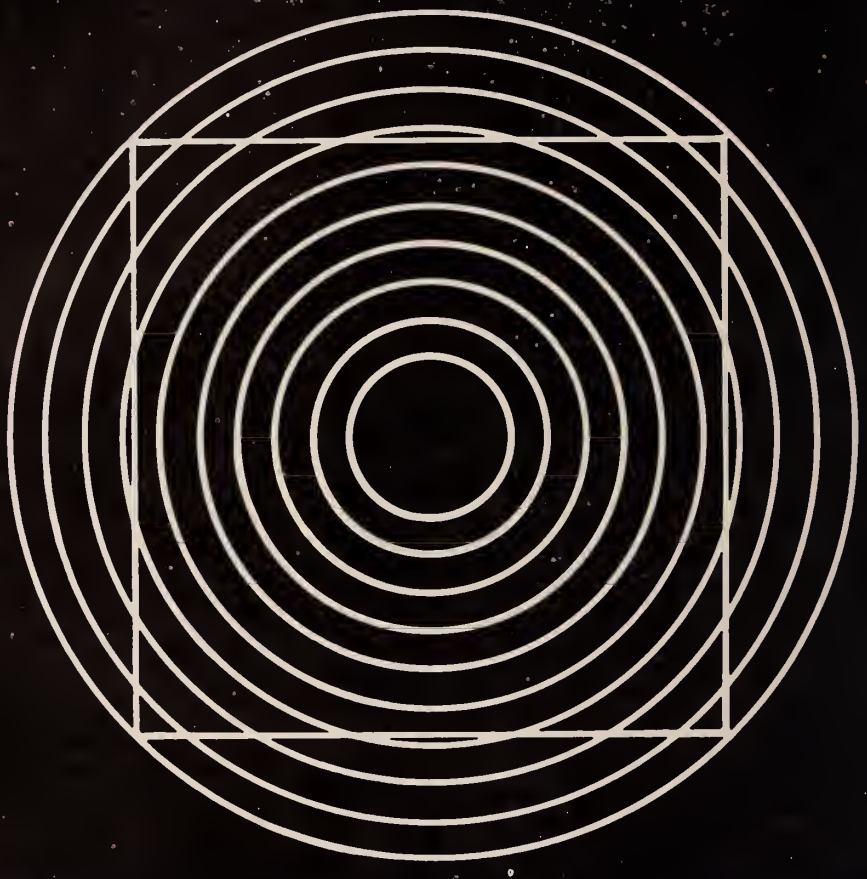


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1. Griffith, R. S.: Antibiotic Med. & Clin. Therapy, 7:129, 1960.

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THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Financial Help for the Intern, Student or Resident

A new nationwide loan plan is giving medical students, interns and residents an opportunity to supplement the financing of their training in a business-like way. Launched recently by the AMA's Education and Research Foundation, the *Guarantee Loan Program* is predicated on individual responsibility, not subsidy. The student or resident gets the money when he needs it most and pays it back when he can afford to. He thus devotes more of his training days preparing for his profession, less to working on part-time jobs to meet expenses. A recent study indicates that three out of ten medical students work more than 20 hours a week. The young doctor then learns early in life the value of careful budgeting and financial planning.

The benefits to the profession and to the public are also clear. Students and residents will be encouraged to complete their training and enter practice. As awareness of the loan program grows, more young people will realize that lack of financial resources need not be a barrier to medical education.

Under the plan, an approved applicant may borrow up to $1,500 in any one year and as much as $10,000 over a seven-year training period. During his training he makes no interest or principal payments.

Repayment starts five months after he enters practice or other full-time employment, on the theory that he is then financially able to begin meeting his obligations.

During the training period each loan carries a fixed rate of simple interest, currently 5½ per cent. When he enters practice, the young doctor can refinance all of his loans into a single note, with a 3½ per cent add-on rate and a pay-out period of up to 10 years.

Medical schools and hospitals help select loan applicants. A bank approves the loan, after reviewing the student's other sources of income (scholarships, family support, earnings, etc.) and projected expenses. The AMA-ERF co-signs each note to guarantee its repayment.

The loans are currently made by the Continental Illinois National Bank and Trust Com-

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pany of Chicago. They are secured by an AMA-ERF fund representing contributions from physicians, medical societies and industry. The bank will lend up to 12½ times the amount in this fund. The fund now has $670,000. A total of $5,900,000 already has been lent or committed to 3,188 applicants, this figure, including the principal and the amount of interest expected to accrue over the lifetime of these loans.

Fifteen of the borrowers are in training in New Jersey.

Remaining guarantee funds provide uncommitted credit of $2,300,000. This sum must be augmented to meet the expected increase in applications in the new school year. The loan program is one in a series of projects sponsored by AMA-ERF, successor to the American Medical Education Foundation and the American Medical Research Foundation. The AMA-ERF loan program deserves the support of all of us. Each $100 contribution will enable some student, intern or resident to borrow $1,250 which, when repaid, will again be available for another student.

It's one of the best ways we know of giving credit where credit is due.

Call Me Mister

A favorite conversational topic in the residents' lounge is whether to call a patient by his first name. This is something they don't teach in medical school. However, a little reflection will show that, in the American culture, and aside from family and old-friends, first names are associated with patronage and inferiority. To call the bootblack "Bill" and the elevator operator "Mike" is to patronize him. It is not a token of familiarity among equals unless it moves on a two-way street. If the patient called by his first name must use "Doctor" in return, this is not an expression of equality.

The use of the last name without the "Mister" is almost unAmerican. It has a contumacious air about it. Nearly always a man feels uncomfortable when he is called just "Jones" or "Miller" without the Mr. Traditionally, it is the label of the servant—the butler is Jeeves, after all; not Mr. Jeeves and not Conrad—but just plain Jeeves.

In the big wonderful world of business, the fashion now is to use initials. To call the boss Mr. Auchinschloss sounds as if you are way below him; to call him Joe would be undue familiarity. So you call him J. M. which nicely bridges the gap.

Sometimes another variable is introduced: the title. You can solve all these problems if you can call the man "Professor" or "Judge" or "Colonel." The titles themselves have a curious anonymity. By stripping the man of what is idiomatically his—his personal name—and falling back on a title (which he shares with a hundred thousand others) you avoid involving yourself too much. The title is thus a comfort to the one who uses it, for it saves him the problem of measuring his exact relationship to the other. And it is a comfort to the one who is so addressed, since it is usually an honorific. In some countries almost every educated man has a title. (Castro is properly called "Doctor" though he never studied medicine; and in France, every lawyer is "Maitre.") And wherever it is desired to squeeze personalities out of a relationship, formal titles abound—the Army being the obvious example.

In some primitive religions a man's name was private, for it was feared that if you knew his name you thereby acquired some mystic power over him. To this day, many people have a vague feeling of discomfort at making known their names. (Sometimes when you ask, you get as a reply: why do you want to know?). Our Bible says: "As his name is, so is he." And the glory and hallowing of Names (Usually with a capital N) appears frequently in the Bible.

Names, too, confer immortality. A man may die, but his sons and their sons carry on the name, until that name seems to acquire a life of its own. The loss of a name is a symbol of degradation. (Remember the old song: "She was poor but she was honest and her parents were the same; till she came into the city and she lost her honest name.")

We usually don't give this much thought whether we call or are called by a first name, by initials, by a title, or by a last name—it all seems to be automatic. But it isn't. It is motivated by strong, unconscious factors which reflect the roles of the two persons concerned.

About patients, the general rule is simple. When in doubt, call him Mister.

Training for Medical Technologists

Throughout the country there are some substandard schools, offering inferior training to ambitious but misled young men and women. These high-priced, high-pressured schools offer to train anyone to be a medical technician or technologist. They can issue a certificate or "diploma" giving their alumni the right to use a set of letters which can confuse even the physician. The doctor who is asked to guide the son or daughter of a patient or friend would do well to warn them that the only safe school is one whose graduates are eligible for the Registry of Medical Technologists sponsored by the American Society of Clinical Pathologists. This registry is in Muncie, Indiana. Its registrants use the proud symbols: MT(ASCP). Also acceptable is membership in the American Society of Medical Technologists—ASMT—not to be confused with several similar combinations of letters. Elsewhere in this JOURNAL is further information about training for technologists.

Enchantment by Research

Hospitals and medical schools like to encourage research. Not only is there magic in the word, but there is also a magnet in it. Research attracts grants, awards, newspaper space, subsidies, and public interest. As a practical matter, an effective researcher may mean more to a medical school than an inspiring teacher. If research leads to the development of something spectacular, like a prosthetic eye with pupillary reflexes or a single-dose, timed release week-end capsule, the school gets its name in more newspapers and magazines than it could ever get by turning out generations of good medical practitioners. When the trustees in a hospital or medical school are considering promotions, the good clinician is less noticeable than the successful researcher.

This is all wonderful, and since our families, our patients and ourselves are beneficiaries of this research we don't want to turn the clock back to the days when all medical care came out of that famous black bag. However, there is a danger here. Not only may this result in the downgrading of the good clinician, but it may actually lead to a kind of disembodied medical practice. The physician with a passionate interest in body fluids sees the person as the container for his fluids—and he is disinterested in clinical complaints. You can't expect a researcher who is enchanted by a small corner of biochemistry to bother much with the patient who has an itch or a joint pain. As medical schools see research as a lure for prestige (and endowments) the faculty balance may subtly shift until fewer and fewer clinicians are doing the teaching. This sets up a chain reaction since teachers naturally try to mould students in their own image.

Perhaps it is time to re-explore the relative emphasis on research and on the care of human beings now coloring our hospitals and medical schools.

VICTOR PARSONNET, M.D.
I. H. SHAH, M.D.
DONALD ROTHFELD, B.S.
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Newark

Closed and Open Chest Cardiac Resuscitation*

A Laboratory and Clinical Study

In cardiac resuscitation, the decision as to method must be made swiftly. There is no time to search the literature. Dr. Parsonnet and his group suggest a simple formula.

Now that almost two years have passed since closed chest cardiac massage was first described by Kouwenhoven and his associates,[1] perhaps it is time for an appraisal of this technic from other sources. Such an appraisal we now present from a group admittedly skeptical, if not downright prejudiced against the newer methods. It is based on experience in 34 animal experiments and in 58 patients.

The two most important factors in the maintenance of life in a patient with primary cardiac arrest are the continued artificial circulation of the blood, and its oxygenation by mechanical expansion of the lungs. The method of achieving the former is the subject of this report. Circulation of the blood in cardiac arrest has been obtained by a variety of methods, such as thumping of the chest, needling of the heart, pumping of the legs, positive-negative artificial respiration, and by pumping the heart itself, as in direct manual or mechanical open chest cardiac massage. It has been asserted that closed chest cardiac massage fits in the last category, on the assumption [2] that movement of the xyphi-sternum toward the vertebral column squeezes the heart between these two bony structures.

We have reluctantly accepted a somewhat backward and perhaps unscientific method of analyzing this technic. Rather than first proving its efficacy and demonstrating its mode of action in the laboratory, we observed from the outset that closed chest cardiac massage works. From there we wished to find out how, when, and on whom it worked, and also when, and when not, to use it.

METHOD

UNDER pentobarbital anesthesia and endotracheal oxygen supplied through a pneophore valve, polyethylene cannulae, attached to strain gauge transducers, were inserted in the

*This work is from the Hemodynamics Department of the Newark Beth Israel Hospital and was supported, in part, by a grant from the Essex County Heart Association. This paper was read May 15, 1962 at the Annual Meeting of the Medical Society of New Jersey.

1. Kouwenhoven, W. B., *et al.*: Journal of the American Medical Association, 173:1064 (1960).

2. Jude, J. R., *et al.*: Annals of Surgery, 154:311 (March 1961).

femoral artery and vein so that their tips lay in the abdominal aorta and inferior vena cava respectively. Continual monitoring of the electrocardiogram and of arterial and venous pressures was done. This was recorded on a four-channel Sanborn Poly-Viso recorder. Blood flow was measured in most animals by the insertion of a bubble flow meter into one carotid artery. However, in the later experiments the flow was measured by the insertion of a bubble flow meter between a common carotid artery and an external jugular vein. The latter method produced a faster and more reproducible flow record.

Ventricular fibrillation (a form of cardiac arrest) was produced by passing 110 volt alternating current of 5 second duration across the intact chest. When initial convulsions and hyperventilation ceased, either closed or open cardiac massage at rates of 90 to 100 per minute was tried for 10 minutes. During this time, all parameters were measured at 3 minute intervals. At the end of the 10-minute arrest period, defibrillation was done, either with external defibrillation counter shock through the intact chest cage, or with an internal defibrillator against the pericardium, using appropriate currents. After resuscitation the initial parameters were again measured.

After pilot studies in 14 dogs, this protocol was followed in 20 consecutive animals. In four of these, after the conclusion of the procedure, the anterior abdominal wall and both pleural cavities were opened wide to eliminate the increase of intrathoracic pressure during continued sternal compression, and arterial and venous pressures were recorded during continued external massage.

RESULTS

Our laboratory experience with 20 animals has produced the results in Table 1. It can be seen that both technics are effective in maintaining life during a 10-minute period of arrested cardiac activity. However, the open technic produces a somewhat higher arterial pressure, lower venous pressure, and higher flow rate. Systolic arterial pressures near normal were not obtained, averaging but 52 and 76 millimeters of mercury in closed and open massage respectively, and venous pressures were far in excess of normal, especially in the closed technic. Flow rates, though apparently adequate for maintenance of life over a 10-minute period, were only 7 and 12 per cent of normal in the two groups.

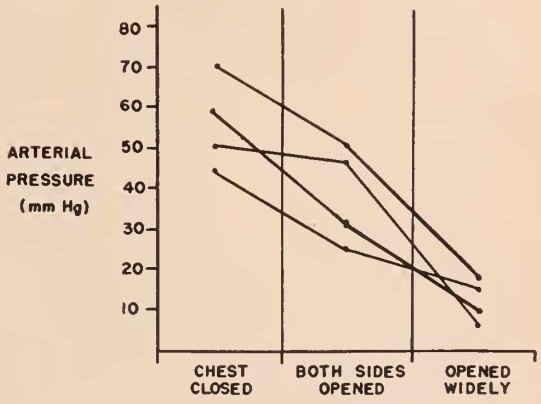


Figure 1. Diagram of drop in arterial pressure during closed cardiac massage as change in intrathoracic pressure is prevented by opening the pleural and abdominal cavities.

Figure 1 demonstrates the effect on arterial pressure of closed chest cardiac massage, when the ability to produce a strong increase in intrathoracic pressure was abolished by the wide opening of the chest on each side. There is a progressive decrease in arterial pressure as the chest is opened wide.

Kouwenhoven [1] has postulated that closed chest massage produces flow by compression of the heart, and by the forward expulsion of its contained blood. If this were in fact the case, would not circulation be maintained in the absence of a rib cage during continued compression of the sternum? We have already shown that such is not the case.

It is reasonable to assume then that the flow produced by massage results, at least in part, from the sharp increase and decrease in intrathoracic and thus intracardiac pressure. Such an interpretation explains why the venous pres-

sure tends to be high during closed massage. It also suggests that closed massage should work better in children in whom the ribs are elastic and resilient, and poorly in the elderly where there is no flexibility in the rib cage. (Fracturing of ribs during such attempts only further decreases the possibility of altering intrathoracic pressure.) This concept is illustrated in Figure 2.

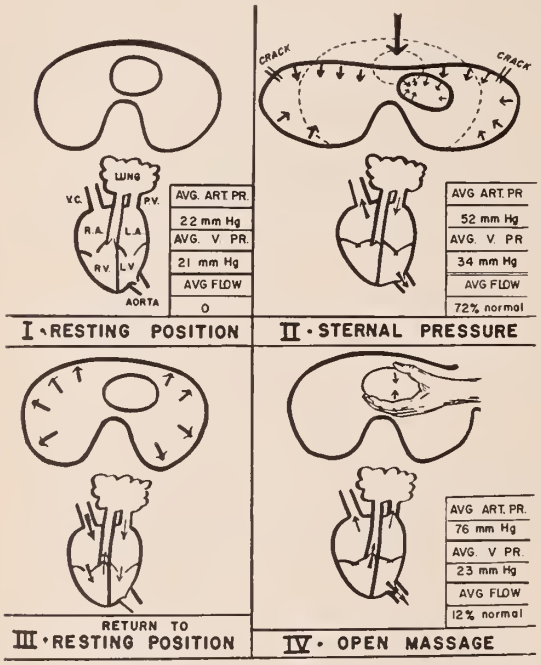


Figure 2. Diagram illustrating the action of closed and open cardiac massage, indicating direction of blood flow, and average arterial and venous pressures and blood flow as actually measured experimentally.

Our clinical experience in 58 patients is shown in Table 2. For the purpose of survival evaluation, only those patients who were treated within four minutes of death are included. The overall survival rate for closed and open massage was 28 and 34 per cent, and the heart was restarted in 64 and 77 per cent respectively. It is of interest that three of the four survivors in closed massage were children. The fourth was a young adult female. On the other hand, only one of the 15 survivors in the open group was a child. The three surviving children in the closed group represent 100 per cent of the children thus treated—the one in the open group was one out of three.

COMMENT

THE striking similarity in results of these two technics indicates that both are capable of maintaining life. The results of our laboratory work suggest slight superiority of the open over the closed method as reflected by higher arterial pressure, lower venous pressure, and a higher arterial flow rate; this is also born out by the slight edge in the clinical results.

Positive intrathoracic pressure is important in producing blood flow in closed chest massage. This suggests that the use of this procedure in aged patients (or in patients with fixed rib cages) should be abandoned if no evidence of flow is obtained after 30 to 60 seconds, or if ribs begin to fracture. Moreover, we have found that many cardiac dysrhythmias can be handled through the open massage technic, and can be recognized easily without an electrocardiogram. The recognition and treatment of many of these are more difficult through the intact chest.

These factors suggest a slight laboratory and clinical superiority of open over closed massage; moreover, a knowledge of the mechanism of this massage leads us to prefer the open technic as treatment of cardiac arrest. We do, however, favor a short trial period of closed massage for 30 to 60 seconds, especially if the full four minutes of grace remain at the start of therapy.

CONCLUSIONS

CLOSED chest cardiac massage is an effective technic for maintenance of circulation in certain cases of cardiac arrest. Its mode of action in dogs is largely through the sharp in-

crease and decrease of intrathoracic pressure, although it is possible that the compression of the heart between the bony structures contributes to the effect.

Closed massage should be attempted in: (1) all cases where facilities for open massage are not available, (2) in all patients where the rib cage is flexible and resilient, (3) in all cases where it can be demonstrated to produce satisfactory flow within one minute, and (4) in all cases where death occurred more than four minutes before resuscitation attempts were instituted.

It should not be used (or its use should be abandoned) when it has been ineffective in restoring circulation, particularly in the elderly patient, and when facilities for open chest cardiac massage are available.

TABLE 1.

	Closed Chest Cardiac Massage	Open Chest Cardiac Massage
Survival	9 of 11 82%	6 of 9 66%
Arterial pressure		
Range	32 - 76	60 - 100
Average	52 mm. Hg.	76 mm. Hg.
Venous pressure		
Range	8 - 70	4 - 40
Average	34 mm. Hg.	23 mm. Hg.
Venous pressure Per cent arterial pressure		
Range	18 - 100	7 - 50
Average	65%	30%
Arterial flow (per cent of normal)		
Range	2 - 11	10 - 14
Average	7.2%	12%

TABLE 2.

CLINICAL DATA

(Includes only patients treated within 4 minutes)

	CLOSED			OPEN		
	Number	Heart Restarted	Survived	Number	Heart Restarted	Survived
In operating room	4	3 (75%)	2 (50%)	26	21 (81%)	11 (42%)
Outside operating room	10	6 (60%)	2 (20%)	18	13 (72%)	4 (22%)
Totals	14	9 (64%)	4 (28%)	44	34 (77%)	15 (34%)

Newark Beth Israel Hospital

Acknowledgment: We gratefully record the technical assistance of Mr. Lester Chapman.

John J. Tambascia, M.D.*
Camden

Magnesium Deficiency Tetany Syndrome in Man

Magnesium deficiency with a resulting tetany syndrome is rare: only five cases have previously been reported. To this meager collection, Dr. Tambascia adds a sixth case.

The magnesium deficiency tetany syndrome was first described as a specific entity in humans by Vallee and his co-workers[1] in 1960. Prior to this, no distinct clinical syndrome of magnesium deficiency (comparable to that which had been observed in animals) had been described in man. That experimental magnesium deficiency produced tetany and convulsions was first shown[2] in rats in 1932. Spontaneous magnesium deficiency tetany had been observed in cattle and was well described 20 years ago.[3 to 6]. Magnesium depletion in animals produces generalized irritability, tremor, convulsions, vasodilatation, dermatitis and decrease in growth.[7]

Hirschfelder[8] first described the clinical symptoms of magnesium deficiency in the nephritic patient in 1934. These findings were confirmed by Flink and his associates[9] 20 years later. Magnesium depletion in man has been shown[7] to produce tremor, muscular twitching, delirium, hallucinosis, behavioral disturbances, convulsions, neurologic signs such as hyperreflexia, auditory hyperacusis, vertical nystagmus, and cardiovascular changes such as tachycardia, hypertension and vasomotor changes.[10]

The entire human body contains nearly 25 Grams of magnesium.[11] It is deposited chiefly in bone, liver, striated muscle, brain and kidney. Only 2 per cent of the body's magnesium is present in plasma[12] and interstitial fluids.[13] At a normal blood pH. approximately 35 per cent[13] of the serum magnesium is bound to protein.[14] The daily requirement of magnesium is about 250 to 300 milligrams which is readily supplied by the average diet.[11] Approximately two-thirds of the magnesium ingested is excreted in the feces. One-third of the magnesium absorbed from the gastro-intestinal tract is excreted in the urine.[14]

Serum magnesium levels below 1.5 milliequivalents per liter are associated in most cases with severe symptoms.[7] Experimental efforts to produce a solitary magnesium deficiency in normal human subjects have consistently met with failure.[15] Although low serum levels of magnesium have been found in a number of clinical states in man,[15] including epilepsy, delirium tremens, cirrhosis, congestive heart failure, eclampsia, pancreatitis, renal disease, hyperparathyroidism, and hyperaldosteronism,[16] all attempts to relate magnesium deficiency as the sole etiologic factor have failed to withstand critical examination.

The magnesium deficiency tetany syndrome is only a recently recognized important entity. Only five cases have been reported.[1] The manifestations correspond almost identically to what has been observed in magnesium depleted states in animals either experimentally[2] or spontaneously.[17]

*Resident in Internal Medicine, The Cooper Hospital, Camden, N. J.

On January 25, 1961, a 47-year old woman was admitted to The Cooper Hospital, Camden, New Jersey. On the day of admission, she had experienced progressive weakness, lapse of memory, and difficulty in performing fine movements. These symptoms progressed to generalized twitchings, impairment of speech, and disorientation. For a whole year, this woman had been maintaining herself on a diet markedly deficient in meat and vegetables. Her diet consisted of one to two quarts of milk daily, together with the ingestion of large amounts of alcohol. Over this time, she had had five to six watery, foul smelling, greasy stools daily. She had lost 25 pounds in weight.

For one year she had noted periodic impairment of memory, confusion and "nervousness." On occasion she noted jerks, or twitches of her upper extremities. These were sometimes bilateral, but occasionally unilateral.

On admission, she had a blood pressure of 160/110. Her temperature was 98.3, and her pulse 100. The signs of tetany manifested by spontaneous carpopedal spasm and a positive Chvostek sign were noted. Tremor and athetoid movements (more common in the upper than lower extremities) were also present. Jarring of the bed produced a notable increase in these movements. The patient was disoriented. Laryngeal stridor was present. Bilateral vertical nystagmus, generalized hyperreflexia, and bilateral positive Babinski reactions were readily observed. The remainder of the physical examination was within normal limits.

On admission, she had a leukocyte count of 5,762 with a normal differential. Hemoglobin was 10 Grams. Urine was alkaline. A serum calcium was 9.3 milligrams per cent, blood sugar 76; carbon dioxide combining power was 64 volumes per cent; blood urea nitrogen 7.0 milligrams per cent; serum sodium 146 milliequivalents per liter; serum potassium 3.28 milliequivalents per liter; and a plasma chloride 89.6 milliequivalents per liter. Alkaline phosphatase 3.2 units, and inorganic phosphorus 3.1 milligrams per cent. A serum magnesium was 0.9 milliequivalents per liter (1.1 milligram per cent).*

On admission, the patient was given intravenous calcium gluconate with no response. Supportive therapy, including intravenous fluids and sedatives was instituted. Minimal response resulted. When able to take oral feedings, she was placed on a high caloric, well balanced diet. The symptoms noted on admission progressively underwent remission. Another serum magnesium on the seventh hospital day was 1.5 milliequivalents per liter* (1.8 milligrams).

While in the hospital, her stools gradually decreased in number from five loose stools (that demonstrated neutral fat and undigested meat fibers) to one well-formed normal stool per day. Radioactive I^{131} fat absorption studies demonstrated no evidence of malabsorption. Roentgenographic studies of the chest, upper gastro-intestinal tract, and an intravenous urogram were negative. Tests of hepatic and renal function were normal. Protein bound iodine was 5.9 per cent. Serum amylase was 116 units. Serum lipase was 0.3 units. Serial serum electrolyte determination, including serum calcium, was within normal limits. An initial electrocardiogram suggested electrolytic imbalance but subsequent tracings were negative.

The patient was discharged on February 17, 1961 completely asymptomatic. A well balanced diet was recommended.

The presence of the magnesium deficiency tetany syndrome in man has again been demonstrated. On the basis of the observation here made, it is possible to characterize the syndrome and discuss the circumstances under which it has been known to occur, and introduce a new possible etiologic factor. Here was a woman who demonstrated all the classical manifestations of human tetany. These included tremor twitches of the extremities, carpopedal spasm, and laryngeal stridor. Latent tetany was shown by Chvostek and Trousseau signs.[17]

Manifestations associated with magnesium deficiency in man were demonstrated by mental aberrations,[7] tachycardia, hypertension,[9] vertical nystagmus,[10] hyperreflexia, and positive Babinski reactions.[18]

Further proof that these observations were the result of an alteration in magnesium metabolism is shown by the failure to reverse the symptomatology by the administration of calcium gluconate. The symptoms of magnesium deficiency have sometimes been controlled with sedation and a normal diet.[18] This was again demonstrated. The final bit of evidence lies in the reported serum magnesium concentration of 0.9 milliequivalents per liter. Correlation was noted between the existence of tetany, decreased serum magnesium, and the disappearance of tetany when the patient was sedated and given an adequate diet, which resulted in an elevation of the serum magnesium to normal levels.[18]

Aberrations in magnesium metabolism can be brought about by (1) alteration in intake; (2) changes in excretion *via* stool or urine; (3) changes in the size of extra and intracellular compartments; and (4) shifts of magnesium between these compartments.[12] Dietary restriction of magnesium[13] does not result in tetany.[19] Malnutrition may result in depletion of magnesium stores, but does *not* produce tetany.

*The Samson Laboratories, Philadelphia. Normal serum magnesium is 1.41 to 2.25 milliequivalents per liter (1.7-2.7 milligrams per cent).

Malnutrition was a factor in this patient as it was in all five cases previously reported by Vallee.[1] But tetany could not have resulted from this alone. This patient demonstrated steatorrhea and chronic diarrhea. This resulted in a decrease in the absorption and increase in the excretion of magnesium in the feces. This defines a conditioned deficiency. Such a deficiency occurs when the normal intake of a nutrient does not fully meet the needs of the organism, because of the presence of unusual secondary circumstances or factors. Other examples of conditioning factors are failure to absorb a substance, excessive excretion of a metabolite, or the inability to synthesize an active intermediate.

In the cases reported by Vallee and his coworkers,[1] the conditioning factors which enhanced the magnesium deficiency were excessive losses from the urinary and gastro-intestinal tract, or intestinal malabsorption. The conditioning factors in these cases appeared, together with a severe debilitating disease, prolonged infection, severe malnutrition, or an alcoholic basis, prolonged postoperative drainage and intestinal malabsorption.

In the case here presented, the conditioning factors, steatorrhea and chronic diarrhea, combined with severe malnutrition on a dietary and alcoholic basis, produce a magnesium deficiency.

Suggestion of another circumstance under which a magnesium deficiency could arise comes from a review of the literature. When rats were placed on a high calcium and a normal magnesium intake, they developed a low serum magnesium while that of the calcium is normal or increased.[15] Hanna and his coworkers [20] have suggested that steatorrhea and high calcium diets impair the absorption of magnesium.

SUMMARY

1. An additional case of human magnesium deficiency tetany syndrome is described. The disorder resembles that which has been observed in magnesium depleted animals and other previously described cases.

2. The clinical and laboratory manifestations of the disease consist of tetany with carpopedal spasm, positive Chvostek's and Trousseau's signs, athetoid movements of the extremities, and mental aberrations.

3. The syndrome occurs in debilitated malnourished states where conditioning factors such as sustained losses from the gastro-intestinal tract, pro'onged intravenous fluids therapy, intestinal malabsorption, and chronic diarrhea.

4. Persistent high calcium diets and steatorrhea should also be considered as an etiologic factor in the production of the syndrome.

5. The manifestations of this syndrome are reversed promptly by parental administration of magnesium sulfate or sedation, and an adequate diet over a longer period of time.

The Cooper Hospital

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Bertold Salzmann, M.D.

Linden

The Postpartum Recovery Room

Routine rectal examination several hours postpartum is an unusual suggestion, vigorously supported in this paper by Dr. Salzmann.

Constant observation of patients for the first two or three hours postpartum must be an integral part of good obstetrical care. The woman should be transferred to a specially designed recovery room. Blood pressure and pulse must be observed and recorded as in any postoperative patient. It is essential to supervise the reaction from sedation used during labor and from spinal or general anesthesia. There is real danger of aspiration of solid or liquid gastric contents. Many a patient has eaten at home as recently as one hour before delivery. Even though many hours may have elapsed between ingestion of food and the administration of anesthesia, the emptying of the stomach is considerably delayed during pregnancy and especially during labor. Suction apparatus and oxygen should be available for use if necessary.

The size, shape and consistency of the uterus should be noted. Relaxation of the fundus should be treated by oxytoxics, preferably a continuous drip of diluted pitocin. No attempt should be made to squeeze or knead the uterus. Such a procedure interferes with the normal attempt of the organ to contract and tamponade the vascular sinuses. Simple holding of the fundus between opposing palms will suffice. If the uterus still fails to contract and hemorrhage ensues the patient should be returned to the delivery or operating room and placed in lithotomy position on the examining table. Careful inspection and palpation of the birth canal must be carried out. A relaxed fundus uteri does not necessarily mean primary atony; such relaxation may be secondary to lacerations of any soft part of the birth canal, *e.g.,* sulcus lacerations, cervical lacerations, rupture of the lower uterine segment or corpus uteri. Retained secundines should be sought. Occasionally, you will find a relaxed distended fundus uteri which is prevented from contracting by a full bladder!

What if the pulse rate of the patient rises and/or the blood pressure declines without additional blood loss? This suggests that the patient had lost more blood during the delivery than was realized. Replacement therapy is urgently indicated. Also bear in mind the possibility of intraperitoneal hemorrhage and try to exclude it by all means. If the patient had not been under constant immediate postpartum observation she may have been "found in shock" several hours later.

The vulva, the labia, and the perineum should be inspected and, if need be, palpated at regular intervals. A rectal examination before discharging the patient to her room is very helpful in discovering a perineal, paravaginal, or pararectal hematoma in its inception. While such hematoma may not be preventable, it may be recognized when it is still small by such simple means as an early postpartum rectal examination! These hematomata are usually discovered when the patient

begins to complain of pain or a "bearing down" sensation. Sometimes these patients will not complain but sink into shock. Such a hematoma may remain unnoticed until it contains a quart of blood.

Postpartum blood pressure may climb steadily and reflexes may become hyperactive. Early discovery and vigorous sedative treatment may prevent a postpartum eclamptic seizure which otherwise would have struck like a lightning in the darkness and silence of the unsupervised ward.

A routine procedure should be adopted before a patient goes "downstairs" from the recovery room. Here are the desiderata: blood pressure and pulse rate should be noted. She should have reacted from sedation and/or anesthetic; the condition of the fundus uteri should be satisfactory; the bladder should not be distended; and final inspection of the perineum should not demonstrate undue bleeding from the vagina nor any protrusion which might be interpreted as hematoma. A rectal examination should exclude any existing accumulation of blood in the pelvis or along the vagina or the rectum.

Thus, care of the obstetrical patient has not come to an end after the expulsion of the placenta. Transferring these women to a postpartum room and leaving them unsupervised may invite disaster. This can be averted by meticulous observation and early institution of reparative treatment.

A modern obstetrical department must have, as one of its integral parts, a postpartum recovery room staffed by competent personnel under whose vigilant eyes, complications will be promptly recognized. We have all seen reports on charts stating that a woman was found in shock postpartum or that a pool of a litre of blood was discovered between her thighs; or that a vaginal hematoma containing 500 cubic centimeters of blood clot was evacuated. These findings mean that these conditions developed while the patient was not observed and were discovered at a time when no great diagnostic acumen was required.

Systematic observation of the puerpera during the first few postpartum hours will aid in early recognition of hemorrhagic complications and, occasionally, prevent the catastrophy of postpartum eclampsia. It will indirectly decrease puerperal morbidity and speed convalescence.

46 Gesner Street

Foreign Physicians Declining

In a recent survey by the Institute of International Education, it appeared that, for the first time in the history of the survey, the total number of foreign physicians had declined. There are now 8,407 foreign physicians from 94 countries; 7,286 were training as residents, and 1,211 as interns. Less than 14 per cent were interns. Last year there were 9,935 reported. The drop is thus 1500 or 16 per cent. This decrease probably reflects the efforts of the American Medical Association to establish sterner criteria for foreign nationals who wish to train in U.S. hospitals.

There were fewer Philippine doctors in the U.S. this year than last, 1,947 against 2,303; yet more doctors come to the U.S. for training from the Philippines than from any other country.

Of the ten countries with the largest number of physician in the U. S., all (except Canada and Germany) showed a decrease. Eleven countries sent foreign physicians to the U.S. for the first time this year: Afghanistan, Algeria, Fiji Islands, Hong Kong, Laos, Liberia, Libya, Malta, Tanganyika, Tunisia and the U.S.S.R.

Sidney Weinhouse, Ph.D

Philadelphia, Pa.

Role of the Liver in Blood Glucose Homeostasis*

In spite of wide fluctuations in sugar intake and sugar utilization, the body maintains its blood sugar level with amazingly little change. Dr. Weinhouse here suggests how this astounding feat of homeostasis is accomplished.

The central role of the liver in regulation of the metabolism of the foodstuffs is nowhere better exemplified than in the metabolism of carbohydrates. The healthy, normal animal maintains a blood glucose homeostasis over a remarkably narrow range, despite a multiplicity of stresses and strains that tend to lower or raise the levels. In maintaining homeostasis the liver plays a dual role: it supplies glucose when needed and it accepts glucose when present in overabundance.

To meet these varied, and sometimes extreme demands, there is exerted in the liver an exceedingly complex interplay of hormonal, dietary, and adaptive effects, about which we still have only a rudimentary understanding. It will obviously be impossible to do justice to this vast subject in the time allotted. For this reason I have chosen to concentrate on one facet, which should be of particular interest to members of this society, namely, the effects of insulin on hepatic regulation of the blood glucose. I shall also restrict my discussion largely to the human.

Hepatic Glucose Production in Fasting

In the basal state, blood glucose is kept constant by a balance between production and utilization. Since the liver is generally regarded as the principal source of blood glucose, the magnitude of these processes in the intact animal may be estimated by direct measurement of hepatic glucose output as revealed by blood glucose concentration differences across the liver. The overall glucose turnover may also be determined, perhaps somewhat more reliably, by carbon ^{14} labeling technics. Figure 1, taken from carbon ^{14}-labeling experiments [1] carried out in our laboratory, demonstrates the simple and straightforward method used. A "trace" dose of carbon^{14}-labeled glucose is injected intravenously, and samples are drawn at regular intervals thereafter for periods of four to six hours. In a fasting, resting normal human, the blood glucose level (broken line) remains constant, while the specific radioactivity (solid line) declines exponentially. This steady drop in radioactivity means that there is a steady dilution of the labeled glucose by the entry of new, unlabeled glucose into the body fluids; and by making several reasonable assumptions, one can easily calculate [2] from the slope the rate of new glucose synthesis. Such studies have shown [2] that the blood glucose is being "turned over" at a rate of about 120 milligrams per kilogram of body

*Presented October 25, 1961, at the symposium on "Liver and Diabetes" cosponsored by the N. J. State Health Department and the State Diabetes Association. This meeting was held at Mountainside Hospital in Montclair. Dr. Weinhouse is Professor of Biochemistry at Temple University School of Medicine in Philadelphia.

weight per hour. For a 70 kilogram man this corresponds to about 8 Grams of glucose per hour.

Most of the glucose produced by the liver in the basal state is needed by the brain. Physiologic studies have established that the brain, which makes up only 2 per cent of the body weight, but uses about 22 per cent of the total breathed oxygen, constantly takes up glucose from the bloodstream[2] at a rate of about 5 to 5.5 Grams per hour. It may not be too far wrong to conjecture that other nervous tissue also utilizes glucose, and if one assumes that the remaining nervous system has a mass a fourth that of the brain,[3] over 6 of the 8 Grams of glucose turned over per hour is accounted for. Evidently the remainder of the body, including even the peripheral muscles, utilizes essentially no glucose at rest. This view would have been considered highly unorthodox only a few years ago, particularly by biochemists, who generally held that muscle tissue could use only carbohydrate; but is in accord with isotope tracer studies, which suggest that resting muscle uses fatty acids as a metabolic fuel.

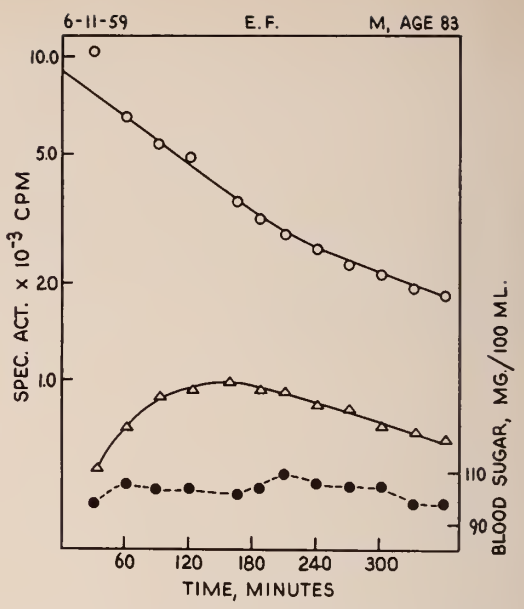


Figure 1. Blood glucose turnover in a non-diabetic individual. Blood glucose level, broken line, dark circles, right ordinate. Blood glucose specific activity, solid line, open circles, left ordinate, plotted on a log scale. Respiratory carbon dioxide specific activity, shown as the solid line, with triangles, is not discussed in this paper. Radioactive glucose was administered at time zero.

GLUCOSE METABOLISM IN HYPERGLYCEMIA

Let us now consider what happens during hyperglycemia. When glucose is ingested, the blood level rises and, in the healthy individual drops rapidly to normal levels. The pattern of response to elevated glucose levels by various tissues is delineated in this table. Uptake of glucose by muscle and other tissues during hyperglycemia is probably controlled at two sites: at the cell membrane, and at glucokinase, the enzyme that initiates glucose metabolism. The recent studies of Levine and Goldstein,[4] Morgan *et al.*[5] and Kipnis *et al.*,[6] perhaps the most decisive information we have on insulin action, have left no doubt that normally the muscle cell is relatively impermeable to glucose. This barrier is overcome by insulin. One can conclude, therefore, that the enhanced glucose uptake is due to enhanced insulin secretion in response to hyperglycemia. Hyperglycemia *per se* can also increase glucose utilization by muscle even in the absence of insulin; but the quantitative significance of this factor is still uncertain. It is probably small in moderate hyperglycemia, but may be very important in severe hyperglycemia.

Once glucose enters the muscle cell it is avidly phosphorylated by the extremely active glucokinase there present. The affinity of this enzyme for glucose is such that at concentrations of less than 10 milligrams per 100 milliliters the enzyme is operating at maximal velocity. The same pattern exists in adipose tissue where again a normally impermeable but insulin-sensitive cell membrane controls glucose uptake.

In brain, there is apparently no permeability barrier and since the brain glucokinase also operates at high efficiency at low glucose concentrations, it may be assumed that in physiologic ranges, utilization of glucose in nervous tissue proceeds independently of the blood glucose level.

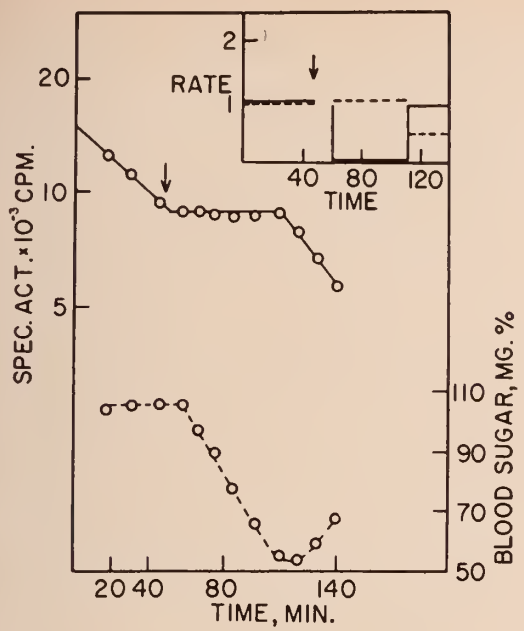


Figure 2. Effect of 10 units of insulin given subcutaneously to a non-diabetic patient weighing 66 kilos, on the time course of blood glucose concentration and specific activity plotted as in figure 2. Arrow indicates time of insulin administration.

The liver, which is a net producer of glucose in fasting, reverses the process [7] and consumes glucose in hyperglycemia. How does the liver "recognize" the high blood sugar level? The liver cell membrane, in contrast with those of muscle and adipose tissue, is freely permeable both to inflow and outflow of glucose.[7] It can, therefore, be inferred that the locus of this responsiveness is at the phosphorylation step. If true, this means that the hepatic glucokinase is of a type not hitherto found in other tissues. This prompted us to carry out a study of the properties of the glucokinase of rat liver. Together with Dr. David DiPietro [8] and Mr. C. Sharma, it was indeed found that liver glucokinase differs markedly from other glucokinases in being highly responsive to glucose concentrations, in physiologic ranges. The muscle and brain enzyme, and the adipose tissue enzyme reach maximal velocity of phosphorylation at below 1 millimolar glucose or 10 milligrams per 100 milliliters, whereas maximal velocity is reached in liver only at about ten times this concentration. It is clear, therefore, why the liver, with a completely permeable membrane, takes up glucose only during hyperglycemia.

EFFECTS OF INSULIN ON HEPATIC GLUCOSE UPTAKE

THE question of an action of insulin on hepatic glucose uptake has been disputed [9] ever since the discovery of the hormone, and the early literature abounds with conflicting reports which, at present, are largely only of historical interest, owing to the inadvertent use of insulin containing varying quantities of the hyperglycemic factor. However, there has arisen in the meantime, a body of evidence which leaves no doubt that insulin may play an important role, indeed, not only in the utilization of glucose, but more importantly, on its production by and release from the liver.

EFFECTS OF INSULIN ON GLUCOSE UTILIZATION

THE most impressive evidence for a role of insulin in hepatic glucose utilization may be found in a series of studies by the group at Harvard [10] on the uptake of glucose by liver slices of the rat, utilizing carbon^{14}-labeling. It was found that the utilization of glucose by liver slices is greatly impaired in the alloxan diabetic rat, but this can be restored to normal by insulin injection. By indirect means these investigators [10] calculated approximate values for the rates of glucose phosphorylation in liver slices under a variety of hormonal and dietary conditions. In rats with normal islet tissue, glucose phosphorylation activity is high, and is not further affected by insulin, but is markedly lowered in the normal animal by fasting. In contrast, glucose phosphorylation is very low in the untreated alloxan diabetic rat liver, and is markedly increased by insulin.

Recent direct enzyme assays of glucokinase in our laboratory (carried out by DiPietro [8]) have also demonstrated a lowered activity of this enzyme in both diabetes and fasting. We have not yet determined whether the enzyme

level responds to insulin injection; however, insulin was inactive *in vitro* in the enzyme system under study.

Investigators have discounted these hepatic effects of insulin as a direct action of the hormone, since the stimulation of hepatic glucose phosphorylation requires pre-injection of insulin for at least six hours prior to their assay. Nevertheless, experiments of this type leave no doubt that insulin lack is closely associated with profound alterations in hepatic glucose utilization.

INSULIN AND HEPATIC GLUCOSE OUTPUT

THAT insulin may play a role in the control of hepatic glucose output has been forcefully emphasized by Soskin and Levine.[11] Their monograph[11] should be consulted for the earlier literature. For present purposes we limit discussion to work of the past ten years, beginning with a demonstration by Bearn, Billing and Sherlock,[12] that in man, the intravenous injection of insulin leads to a profound lowering of hepatic glucose output. Arterial and hepatic vein blood (obtained by venous catheterization) was compared before, during and after insulin injection. Immediately after insulin injection and throughout the period of blood sugar fall the difference between the arterial and hepatic venous blood sugar became very small, and these did not diverge again until the blood sugar level began to rise about one-half hour later. The hepatic glucose output, calculated as the product of the blood sugar differences and the hepatic blood flow, thus dropped sharply immediately upon insulin injection, then during recovery rose to above the original level. The same phenomenon was observed not only in normal but also in diabetic subjects. Here is a clear-cut, immediate suppression of hepatic glucose output by insulin. We undertook a further study[13] of this phenomenon, using the isotope tracer technic, first in dogs and then in humans. The results were completely in accord with the preceding experiments of Bearn, Billing and Sherlock,[12] in pointing to an immediate suppressive action of insulin on hepatic glucose output. The experimental basis for this view may be seen in figure 2. A normal, fasting subject was given an intravenous injection of a trace of carbon[14]-labeled glucose, and at intervals samples of blood were withdrawn and assayed, as previously described. While the glucose level, shown by the dotted line, remained steady, the radioactivity declined at a steady rate, as shown in figure 2. Shortly after a subcutaneous injection of insulin, the radioactivity "plateaus"—that is, dilution of radioactivity ceases, which we interpret as a cessation of hepatic glucose output. Simultaneously, there is a drop in the blood sugar which coincides with the plateau in specific activity. After about 50 minutes, the blood sugar again rises and simultaneously dilution again ensues, as shown by resumption in the decline of radioactivity.

In the meantime, various other investigators also studied the same question by measurement of changes in glucose concentration across the liver, using a variety of technics essentially similar in principle to that of Bearn, Billing and Sherlock.[12] The data are conflicting; some[14 to 19] observe a suppressive action, while others maintain that insulin has little or no effect.[20,21,22]

Essentially all investigators who have studied this problem by isotope tracer technics agree that insulin suppresses hepatic glucose output, but differ concerning the magnitude of this effect,[23 to 27] or its significance in blood glucose homeostasis. Recent studies[28] of Leonards *et al.*[29] using a combination of both catheterization and isotope technics, indicate that the diet may play a role in the responsiveness of the liver to insulin. When dogs were fed a previous diet high in protein and low in carbohydrate, insulin had little or no effect, but when previously fed a high carbohydrate diet, insulin induced an immediate decrease in hepatic glucose output.

In appraising possible actions of insulin on the liver, two observations in particular were regarded as especially significant. The first is derived primarily from our own aforementioned studies.[13] When insulin was given intravenously, the suppression of hepatic glucose out-

put was short-lived and a large component in the ensuing hypoglycemia was an enhanced glucose uptake. However, when insulin was given subcutaneously, suppression was prolonged, and little if any increase was observed in glucose uptake. It thus appeared that when insulin reaches the blood stream gradually, its effects may primarily be hepatic rather than peripheral. Support for this view was obtained from experiments on the action of tolbutamide. Injection of this drug caused the same type of "plateauing" of specific activity as did subcutaneously injected insulin, and since it seems fairly certain that tolbutamide acts by eliciting insulin secretion, it can be assumed that the physiologic secretion of this hormone, into the portal vein where it has to traverse the liver before reaching the general circulation, may limit hepatic glucose output without materially affecting peripheral utilization.

More evidence of an hepatic action of insulin, as well as a further clarification of the action of the hypoglycemic drugs, has been brought forward by Frawley *et al.*,[30] to support the view that endoportally secreted insulin affects the liver primarily.

The second point to consider is the production of glucose in the diabetic. One may assess the action of a hormone no less by what happens in its absence than by what it may do directly; and there is now available a considerable body of evidence[1] to establish that glucose overproduction is a characteristic feature of the diabetic state. This has been attributed in the past to a compensatory mechanism, to bring the blood sugar level up to where peripheral utilization can match that of the normal subject. However, this does not explain why severe, uncontrolled diabetics may exhibit fantastically high blood glucose levels while excreting huge amounts. It seems more reasonable to assume that the overproduction of glucose in the diabetic is a manifestation of a physiologic impairment of liver function.

On the basis of these and previous considerations, we can formulate the homeostatic action of insulin in the following terms. A slow, steady secretion of insulin flows from the pancreas into the liver *via* the portal vessels and suppresses the hepatic outflow of glucose. Because the liver has an avidity for insulin, probably very little escapes into the systemic circulation, and in the absence of insulin stimulation, little if any glucose is utilized by the peripheral tissues. Presumably the musculature utilizes the circulating protein-bound fatty acids for its resting metabolism.

When glucose enters the blood stream and the blood glucose level rises, insulin is secreted in larger quantities, which escape the liver and enter the peripheral vessels to cause an increased transport and consequent peripheral utilization of glucose. At the same time the hepatic glucokinase begins to function; the liver begins to take up glucose, and the heightened insulin secretion apparently acts on the liver to activate glycogen synthesis, and to maintain glucokinase at a high level. The net effect of these actions is to enhance the removal of glucose by liver and to suppress the normal hepatic glucose output.

TABLE 1.

PATTERNS OF GLUCOSE UTILIZATION

Tissue	Permeability	Insulin Responsive	Glucokinase
Muscle	—	+	Independent of glucose level
Adipose	—	+	" "
Brain	+	—	" "
Liver	+	—	Dependent on glucose level

TABLE 2.

BLOOD GLUCOSE REPLACEMENT IN HUMAN SUBJECTS

Condition	Glucose Turnover mg/kg/hr
Normal	120 ± 17
Mild diabetic	88 ± 5
Severe	207 ± 38

In the table, there may be seen a summary of blood glucose turnover data obtained by us by means of the isotope tracer technic.[1] In the mild diabetic, turnover (that is, both output and utilization) is somewhat lower than normal, but is considerably greater than normal in the severe diabetic. Similar observations[31] have been made by several other laboratories[32]

in man. The concept of hepatic capture of endoportally secreted insulin suggests why blood glucose turnover may be normal, or even subnormal in the mild diabetic and excessive in the severe diabetic. The mild diabetic may be presumed to be secreting some insulin, but since this limiting quantity has to traverse the liver, peripheral glucose utilization is likely to suffer before any marked effects are seen in the liver. This would lead to subnormal glucose turnover even with moderately elevated blood glucose levels. In severe diabetes, relatively total insulin lack would affect the liver as well as the periphery, and it is precisely in this condition that one sees extremely high and uncontrollable blood sugar levels, far above what would presumably be necessary for adequate peripheral glucose uptake, even without insulin.

If one assumes an hepatic action of insulin in regulating hepatic glucose ouput, with consequent glucose overproduction in insulin lack, it becomes possible to explain certain biochemical phenomena, long associated with diabetes, that otherwise have been difficult to understand. These are: an impaired synthesis of fatty acids, an increase in the production of the so-called ketone bodies, acetoacetic and β-hydroxybutyric acids, leading to ketonemia and ketonuria; and in severe diabetes, a "wasting" of protein. A detailed consideration of the enzymatic processes of glucose production by the liver reveals several key metabolic interrelationships which would plausibly explain how an augmented glucogenesis might result in reduced fat synthesis, increased ketogenesis, and protein breakdown. These are subjects of future experimental studies.

At present we do not know the enzymatic locus of insulin action, nor that of any other hormone. Moreover, any conception of metabolic regulation based on the action of a single hormone is bound to be extremely oversimplified. We recognize that the adrenals, pituitary, and probably the thyroid all contribute to blood glucose regulation, but we know less of their action even than that of the pancreas. We have not discussed other factors involved in the blood glucose homeostasis; for example, how the powerful adaptive mechanisms of the liver operate so as to store glucose as glycogen at a prodigious rate during hyperglycemia; nor have we discussed how the liver breaks down this glycogen and synthesizes glucose with the extreme rapidity required to meet the extravagant demands for glucose during muscular work. The magnitudes and the mechanisms of these processes which are in part controlled by adrenal hormones are still uncertain. Clarification of these problems, as well as the respective roles of insulin in controlling hepatic glucose output on the one hand, and peripheral glucose utilzation on the other, must await more fundamental biochemical and physiologic studies.

Temple University School of Medicine

A bibliographic listing of 32 citations appears in the author's reprints.

Chemotherapy in Tuberculosis

"William S. Middleton, medical director of the Veterans Administration says that the VA has closed down 11 tuberculosis hospitals in 10 years. In 1950 there were 21 hospitals with 15,690 beds. Today there are only 10 TB hospitals with 9,037 beds. The institutions for tuberculous veterans maintained by taxpayers have been cut by more than 50 per cent, with all that means in savings to all of us. Primary reason for this decline in the cost of medical care for tuberculosis is drugs. Dr. Middleton attributes the VA record to new and specific drugs in TB chemotherapy produced by our ethical drug industry." — Austin Smith, M.D., President, Pharmaceutical Manufacturers Association.

William A. Anderson, M.D.

Bloomfield

Experimental Stimulation of Breast Development in the Teen-Age Female

The breast of a teen-age girl seems more responsive to hormone stimulation than that of the adult; and less likely to revert to its previous size after cessation of therapy.

It is a rare physician who has not been consulted by women desirous of increasing the size of their breasts. In the last decade of Hollywoodism, emphasis has been placed on mammary development as the symbol of femininity. Many women, not generously endowed by nature, have become self-conscious about this. They feel inadequate in their feminine role. These feelings have been passed on to our enlightened teen-agers who, like their mothers, share this feeling of inadequacy and seek solace in the padded bra. However, there is no objective criterion of "underdevelopment" here. There is no standard as to the amount of bust line any figure should have.

Consultation with over a dozen bra manufacturers has cast little light upon the subject. Statistics are neither informative or conclusive. As one company [1] points out: "Statistics will give a completely distorted picture since many women will buy separate pads to wear in regular bras; and there are those who alter their bras."

PHYSIOLOGY

The breast normally retains its infantile contour [2] until between the ages of ten and fourteen. By sixteen, the average teen-ager has a good picture of her own breast development. She is either resigned to the use of "falsies" or is happily filling out her bra in adequate proportions.

The accepted theory [3] of mammary development has been that once gonadotrophins are produced in significant amounts, the gonadal hormones are responsible for subsequent breast changes by direct end target action.

Turner [4,5] and his associates have suggested that the gonadal hormones act only as stimulants to the pituitary with the production of mammogen I and mammogen II. The former is produced in response to the stimulation by estrogen and results in ductal development. The mammogen II develops in response to both estrogen and progesterone and results in lobulo-alveolar growth.

Nelson [6] cites experimental evidence which

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suggests that the pituitary hormone, prolactin, plus the ovarian hormones estrogen and progesterone are necessary for mammary growth. In animals the relative roles of progesterone and estrogen in breast development differ so much among experimental laboratory animals that it is difficult to compare them with the human breast. However, it appears that even though the breast will enlarge under estrogen the glands will be more normal histologically if a suitable amount of progesterone is added.

Ingelby[7] found in a small series of adolescent girls alveoli were absent prior to the beginning of menstruation. When progesterone first appears at puberty the alveoli and lobules begin to form and the breast develops into its adult structure.

One remarkable feature of mammary epithelium is its ability to respond to hormonal stimulation. In an adult it would appear that the changes are reversible when estrogens are given.

Since the introduction of the hormonal control of ovulation by the use of norethylnodrel with ethynylestradial 3-Methylether,[8] I have been impressed by the amount of breast engorgement and increase in size in some women. For the most part this is completely reversible.

Based on the premise that estrogen and progesterone would produce a nearly normal histologic growth in the breast and that the mammary epithelium is sensitive to hormonal stimulation the following experiment was carried out.

PROCEDURE

AN estrogen-progesterone combination was administered to "flat chested" teen-age girls. Their ages varied from fourteen to nineteen. These girls were measured monthly for three months prior to administration of the hormones. Those showing no change in breast size were selected. Thirteen acceptable teen-agers were placed on the dosage of hormone needed to suppress ovulation: 10 milligrams daily beginning on the fifth day for three months. Breasts, hips, waist, thighs and weight were measured after each menstrual period for this three-month period. At the conclusion of medication an additional three months were allowed to elapse before final measurements were recorded. Five (under-developed) adults were measured for comparison. In one instance, the mother of two of the teen-agers was so used.

Of the thirteen youthful subjects four discontinued the hormone because of nausea and vomiting. This side-effect incidence was much higher than in a similar adult group. Two of these discontinued the medication immediately after the first dose. The other two persisted for one and two months. Their measurements are included in this study.

RESULTS

EACH teen-ager noticed an increase in the size of her breast. This was accompanied by a marked tenderness and some broadening of the hips by the end of the first month. By the third month, maximum growth appeared to have taken place. This was unaccompanied by any noticeable pigmentation of the nipples. This feature of this type of combined therapy is in marked contrast[9] to that which occurs with ingestion of stilbesterol.[10] Prominent stretch marks *did* appear attesting to the rapidity and extent of the mammary development.

Three months after the hormones had been discontinued there had been a reduction in the size of the breasts in all but four. But unlike the adult control group their breasts did not return to their original size. In the four subjects whose breasts did not diminish in size there was still no change six months to one year later.

Maximum growth was found to have oc-

7. Ingelby, H.: Archives of Pathology, 33:573 (1942).

8. Enovid supplied for experimental use for this project by G. D. Searle & Co., Chicago 80, Illinois.

9. Cook, C. D., McArthur, J. W. and Berenberg, W.: New England J. Med., 248:671 (1953).

10. Davis, M. E., Boynton, M. W., Ferguson, J. H. and Rothman, S. J.: Clin. Endocrinol., 5:138 (1945).



Left figure shows breasts before therapy. The figure on the right shows breast size six months later, which was 3 months after cessation of therapy.

curred in one 16-year old. Her bust measurements increased from 31½ to 35½ inches in three months time. Three months later the bust line had decreased by one inch. See the figures.

The minimum response was in a 19-year old, whose measurements went from 33 inches to 34½ inches in three months, with a decrease of 1 inch three months after the cessation of therapy.

Of the eleven volunteers, average growth was 2 inches in three months. Minimum growth was 1 inch and the maximum was 4 inches. Three months after cessation of therapy, minimum overall increase was ½ inch; maximum was 3½ inches; an average was 1½ inch.

In the four adult subjects, after three months, maximum growth was 2¼ inches with a minimum growth of no inches. Three months after the experiment had been concluded, breasts had returned to previous size, with the exception of one 20-year old, whose breasts remained 1 inch larger than her original measurements.

CONCLUSIONS

It is possible that the combination of estrogen and progestin in the ratio found in Norethylnodrel® with ethynylestradial 3-Methyl-ether [8] can favorably influence the development of the underdeveloped breast in the teen-age female. This study was carried out in a small number of girls and for a period of only six months. It does offer evidence that the teen-age breast is more susceptible to hormone stimulation than the adult breast and the effects are not completely reversible.

1310 Broad Street

Floyd J. Donahue, M.D.

Elizabeth

The Suture Sinus*

The annoying and persistent suture sinus may be eliminated by a simple technic here described by a surgical resident at Bellevue.

A common problem in the postoperative management of surgical wounds is the suture sinus. Non-absorbable silk and cotton are being increasingly used in surgical closures. This is related to manufacturing methods and to the development of highly refined suture materials.

Any time after the fourth postoperative day, and especially after the removal of the skin sutures, small areas of purulent drainage present themselves at the site of a previously removed skin suture. This may persist for indefinite periods. It is usually the result of a staphylococcal infection, which focuses about a non-absorbable suture somewhere in the tissues below the skin. Such a sinus will remain until the removal of the suture, about which the infection forms. The suture serves as a foreign body nidus for continued infection.

Many technics are used to treat this complication. Methods include the use of forceps or hemostats for the removal of the sutures. The purpose of this paper is to describe a method which has been used at the out-patient surgical clinics on the New York University Division at Bellevue Hospital for a number of years. This technic has repeatedly been proved successful.

An ordinary metal crochet needle (which is readily purchased for 15 to 20 cents) is used. The needle may be sterilized in any surgical solution. It is inserted into the sinus tract to the depth of its base, and gently rotated while being withdrawn from the tract. Not infrequently, a suture will immediately hook on to the needle and is then easily removed.

This method, however, is not without failure. If a suture is imbedded into the tissues too firmly, it is not easily removed with the needle alone. If the sinus tract is then probed with two or three silver nitrate-tipped sticks, its lining and the tissue holding the incriminating suture are cauterized. This loosens the impacted suture from the binding tissue. At the next clinic or office visit, two or three days later, the suture may be withdrawn easily with the crochet needle as previously described. Subsequent closure of the sinus tract will then rapidly take place. On rare occasions it has been necessary to make repeated applications of the silver nitrate sticks before extraction of the suture is achieved.

Conclusion

Through the use of a simple crochet needle and inexpensive silver nitrate sticks, the problem of suture sinus is minimized. This means the elimination of countless revisits.

*This paper is from the Department of Surgery at Bellevue Medical Center, New York City.

7 Tudor Court

Trustees' Meeting

June 17, 1962

A regular meeting of the Board of Trustees was held on Sunday, June 17. Following is a resume of the significant actions taken:

Disaster Medical Care Conference . . . authorized Dr. Jack Karel, chairman of MSNJ's Committee on Disaster Medical Services, to attend the 10th annual national conference, sponsored by the Council on National Security and the AMA in Chicago on June 23.

AMA National Congress on Mental Health and Illness . . . authorized Dr. Robert S. Garber, chairman of MSNJ's Committee on Mental Health, and President Louis Wegryn to attend the Congress in Chicago on October 4-5.

Seminar on Psychiatry . . . authorized the listing of MSNJ as a sponsor of the 4th Seminar Series on Psychiatry for the General Practitioner, to be held at The Carrier Clinic, Belle Mead from September 12 to October 19.

Professional Convention Management Association . . . authorized Mrs. Edith L. Madden, Administrative Secretary—member of the Board of Directors of PCMA—to attend the Chicago meeting on June 24-25 and the Florida meeting on January 2-5, 1963; total expenses of the trip—not to exceed $425—will be charged against the annual meeting account.

AMPAC . . . authorized those officially attending the AMA meeting in Chicago—President, President-elect, 6 Delegates, 1 Alternate-Delegate, Executive Officer—to represent MSNJ at a $25-a-plate banquet, to support the American Medical Political Action Committee.

Fluoridation . . . reaffirmed its previous actions in the name of MSNJ approving the fluoridation of public water supplies in this State, under regulations promulgated by the State Department of Health.

Disaster Medical Services . . . approved the following recommendations of the committee:

1. *First Aid Equipment for School Buses* . . . that the following items be eliminated from the present first-aid kit: iodine swabs, ammonia inhalants, burn ointment, tourniquet, and boric acid eye ointment; and the following items be added to the first-aid kit: 4 x 8 inch gauze pads (carlisle-type are recommended—which may be obtained from the Guild Products Corp., Newark; and/or Bauer and Black, Chicago).

2. *Medical Self-Help Program* . . . that the medical self-help program be a mandatory part of each child's education at high school level, and that the State Commissioners of Education and Health be so advised.

3. *Civil Defense Laws* . . . that, through the instrumentality of an article—prepared and submitted by the committee—in both the *Membership News Letter* and THE JOURNAL as well as an official communication to component societies, members of MSNJ be informed of existing civil defense laws and the members' responsibility under them.

4. JOURNAL *Articles* . . . that, subject to the concurrence by the Publication Committee, Commissioner Kandle be encouraged, and asked to continue, to submit for publication in THE JOURNAL of MSNJ appropriate articles on civil defense and medical aspects thereto.

1963 *Annual Meeting* . . . approved the joint report of the annual meeting committee and section officers, held on June 10:

1. 1962 annual meeting excess income over expenditures (approximate, because a few bills are outstanding) $4,926.88.

2. 1963 overall schedule—same as 1962.

3. Maximum limit for scientific exhibits—15 feet length, six feet depth.

4. Scientific and educational exhibits, and motion picture theatre to open on Sunday afternoon, May 12, 1963.

5. Technical exhibits to open Monday afternoon, May 13, 1963.

6. Large social functions to be held in the Chalfonte.

7. Scientific sections:

   Tuesday morning, May 14—2 joint, 1 single

Tuesday afternoon, May 14—2 joint, 1 single
Wednesday morning, May 15—2 joint, 1 single

8. The committee is of the opinion that the Woman's Auxiliary should return to its former schedule of carrying some of its activities over to Wednesday, instead of closing at noon on Tuesday.

9. No luncheons or group meetings will be scheduled during the day, except Wednesday, May 15, beginning at 1:00 p.m., or 4:30 p.m. or later Saturday through Tuesday, May 11-15, 1963.

Tuberculosis Screening Program . . . approved the recommendations of the State Tuberculosis Council—received through MSNJ's liaison representative, Dr. John B. Fuhrmann—to change the tuberculosis screening program in public schools of New Jersey as follows:

1. Pupil testing or examination in grades 1, 5, 9, and 12 instead of in grades 9, 10, 11, and 12.

2. Inclusion of the word "intradermal" before "tuberculin test" in several places, for clarity.

3. Proposed recommendation: The Tuberculosis Council recommends that the intradermal tuberculin test is the method of choice to be used in screening programs. It further recommends that the generally available tests—commonly known as the Mantoux, Tine, Heaf, and Stern Needle—are acceptable for purposes of tuberculosis screening.

Use of M.D. Decals . . . received the report of MSNJ's liaison with the Division of Motor Vehicles, Dr. A.M.K. Maldeis, concerning the placement of decals on automobiles: inspection station procedure provides for approving vehicles with MSNJ's decal displayed on the rear window or rear side window, provided the driver's vision is not interfered with, and vehicles are not rejected for displaying this decal alone. (If there is instance of rejection for this reason alone, the Division will be happy to investigate it.)

Medical Student Loan Fund . . . approved the report of the committee granting loans totaling $18,600 to 19 applicants.

AMA Lists of Physicians . . . directed that a letter of inquiry be sent to the AMA to investigate and clarify the intention of Resolution No 10—not adopted by the House because "it was not clearly stated whether the list mentioned was the official AMA Directory or a specialized list."

Internships in Community Hospitals . . . prepared the following resolution for introduction by the New Jersey delegation at the AMA annual meeting—by direction of the House of Delegates, as contained in Resolution No. 11:

The following is the approved resolution sent to Chicago:

Whereas, there is a shortage of medical school graduates to fill the available internships in approved programs in the numerous community hospitals within the United States; and

Whereas, these community hospitals are the backbone of medicine as practiced in this country and offer the medical graduate the opportunity to develop a position in medicine at the community level where he will eventually practice; and

Whereas, there are recent trends by large medical centers to corral all graduates into their programs by offering straight internships and opportunities in residency programs to those accepting such interships; and

Whereas, in many community hospitals sound intern-training programs have been established by the hospital staffs, offering educational advantages at least equal to those available in medical centers, where interns frequently function chiefly as ancillary laboratory assistants; therefore be it

Resolved, that the American Medical Association recognize the dangers to medical graduates, community hospitals, and the public at large inherent in the present practices of medical centers to pressure medical graduates to intern in medical centers, and take the necessary steps to encourage medical graduates to intern in community hospitals of their choice.

Implementation of 1959 Resolution . . . instructed New Jersey's delegates to the AMA annual meeting to support the Indiana State Medical Association, which resolved:

At the 1959 AMA Interim Session in Dallas a resolution was adopted calling for appointment of a committee to study the problem of intern training and out-patient service. The current resolution points out that the 1959 action has not been implemented, a committee has not been named, and no report has been presented to the AMA House of Delegates.

Resolved, that the appropriate officer, or officers, of the AMA cause the intent of this (1959) resolution to be carried out without further delay and that this committee be or-

ganized so as to present a progress report no later than the interim meeting to be held in November 1962.

AMA Alternates-Delegates . . . named Dr. Joseph R. Jehl to serve as a delegate in place of Dr. L. Samuel Sica, who could not attend; and Dr. Frank J. Hughes to substitute for Dr. Jehl, who was previously authorized to attend as the Society's one alternate-delegate.

Atlantic City Convention . . . designated Dr. C. Byron Blaisdell to speak for MSNJ in urging the AMA to return to Atlantic City for its annual meetings any time from 1966 through 1970.

Hospital Formulary . . . reaffirmed its action of October 16, 1960 that:

> As a means of reducing the costs of drugs to patients in hospitals by having them ordered under generic rather than trade names, it is recommended that The Medical Society of New Jersey endorse in principle the proposal that hospitals of New Jersey establish a formulary system, provided that the details of the system be worked out on a basis satisfactory to the members of each individual hospital staff.

Referrals from 1962 House of Delegates:

1. *MSP Board of Trustees* . . . received and noted for future reference, recommendation of the reference committee—adopted by the House—"that the physicians from South Jersey and general practitioners be included in future lists of nominees."

2. *Financial Reports* . . . received and noted Resolution #4, which called for the Treasurer and Trustees "to continue to use capital funds in such a way as to obtain the largest return possible, consistent with the principles of prudence and safety."

3. *Public Education Program* . . . referred to the Council on Public Relations Resolution #13 "for study and implementation."

4. *Kerr-Mills Act* . . . agreed that convention publicity had taken care of the subject of two resolutions (#14 and#19).

5. *Resolution of New Jersey Assembly* . . . agreed that no action was necessary on Resolution #20, since A-755 had been withdrawn.

6. *Basic Minimum Hospital and Nursing Home Plan* . . . held for study "between now and the next annual meeting" Resolution #23.

Correspondence:

1. *Woman's Auxiliary Resolution* . . . received with appreciation a resolution adopted by the Auxiliary at its 35th annual meeting extending sincere thanks to MSNJ for services rendered.

2. *Annual Meeting Section Name* . . . approved, effective at once, change of the name of the "Section on Neuropsychiatry" to "Section on Psychiatry and Neurology," in keeping with the terminology in use today.

King-Anderson Bill Debate . . . designated as official representatives of MSNJ—in compliance with an invitation to send members to a luncheon preceding a New Jersey-AFL-CIO-sponsored debate concerning the King-Anderson Bill in Newark on June 27—Doctors Jesse McCall of Newton, Marshall F. Driggs of Englewood, David Eckstein of Trenton, Joseph M. Gannon of Plainfield, and Emanuel M. Satulsky of Elizabeth.

Guide of Relationship between Physicians and Hospitals . . . assigned to the Council on Medical Services the project of making a study of physician-hospital relationships in New Jersey and set up a recommended guide of relationship between the two.

Doctor Needed for Central African Project

The New Jersey State College at Glassboro has accepted the challenge of helping start a teachers' college in Uganda. They need a physician, preferably one in Southern New Jersey, to serve as a consultant in public health in related matters. The physician may have the opportunity of spending part of the summer of 1963 in Central Africa.

Any doctor willing to participate in this project is asked to communicate with the "Operation Uganda," Glassboro State College, Glassboro, New Jersey.

Announcements • • •

Diabetes Symposium

Diabetes, in children and young adults, is the subject of a colloquium to be held under the joint auspices of the State Health Department and the New Jersey Diabetes Association on October 31. The meeting will be held in the main auditorium of the Prudential Insurance Company at 763 Broad Street, Newark, New Jersey.

Three papers are scheduled: *Diabetes in Children and Young Adults* by T. S. Danowski, M.D.; *The Infant of the Diabetic Mother* by Franklin C. Behrle, M.D.; and *Mental and Emotional Problems of Children with Diabetes Mellitus* by William Weil, M.D.

The program starts at 2:00 p.m. and will adjourn promptly at 5:00 p.m. You are invited.

Laboratory Methods in TB

Two free courses in "Laboratory Methods in the Diagnosis of Tuberculosis and Related Mycobacterial Infections" are announced by the U. S. Public Health Service. One will be during the week of January 14, 1963, and the other during the week of January 28, 1963. The meetings are held in Atlanta, Georgia, and opened to laboratory personnel approved by their state health officer.

For further details, write to U. S. Public Health Service, Communicable Disease Center, Atlanta 22, Georgia.

Course in Diet Therapy

Rutgers University announces a course in Diet Therapy for hospital personnel and nursing professions. The program is given in Cherry Hill, New Jersey (Camden County). The courses will be given on Wednesdays. The first is scheduled for October 17 and the last on November 7.

For further details, write to University Extension Division, 35 College Avenue, New Brunswick, New Jersey.

Automotive Medicine

The American Association for Automotive Medicine will hold its annual meeting November 7, 8, and 9 at Alamogordo, New Mexico, and the Holoman Air Force Base. The educational program is under direction of the University of Minnesota. The scientific program will constitute the Sixth Stapp Automotive Crash and Field Demonstration Conference.

The tentative program includes a tour of the Aeromedical Field Laboratory, a cocktail party, a dinner; papers by the American Association for Automotive Medicine, a membership meeting, an outing; demonstrations of Colonel Stapp's rocket sled (now being used to conduct acceleration-deceleration tests with brown bears) in various postures and the effects of axial forces such as are produced by the activation of the ejection seat while in motion. The formal portion of the meeting will be followed by a group expedition to Jaurez, Mexico, over the long weekend following.

A program for the wives has also been developed. Information on this subject and on motel reservations may be obtained from Dr. Harold A. Fenner, 115 West Sanger Street, Hobbs, New Mexico. You are welcome. It's instructive—it's interesting; and it's diverting!

Medical Passport

For some years now, efforts have been made to develop a simple, portable medical record file that the patient could keep and show to his physician if he moved, or became ill away from home. Many versions of this portable health record have been developed. Latest, and perhaps most ambitious, is the "Medical Passport" issued by the nonprofit "Medical Passport Foundation." It is made available in two forms. One, the size of a small passport, can be carried in the jacket or handbag and is intended for travellers. The more elaborate form

fits into a full-sized manila folder and has space for everything from electrocardiogram paste-ups to an immunization register. It has room for recording ova found in feces, coagulation time, dates of radiation exposure, birth weight and so on. The document may be used as a springboard for building a hospital chart, and it will also get any patient off to a head start when he visits a new doctor. Copies or further information may be obtained from the Medical Passport Foundation, 35 East 69th Street, New York 21, N.Y.

Leukemia Study Now Underway

Patients with chronic myelogenous leukemia are eligible for a clinical study now being made by the U.S. Public Health Service. Patients selected for participation will be given some of the newer chemotherapeutic agents. For details, write to Chemotherapy Service, National Cancer Institute, Bethesda 14, Maryland. For immediate information about the acceptability of your patient, phone 496-4[illegible] Bethesda, Md.

Chest Disease Seminar in Orange

A seminar on the pathology of tuberculosis and related chest diseases is scheduled for Wednesday, October 31, 1962 at the Veterans Administration Hospital in East Orange. The program is sponsored by the New Jersey Tuberculosis and Health Association with Christmas seal funds. Cooperating are the State Department of Health, New Jersey Society of Pathologists, Veterans Administration and the Federal Department of Health, Education and Welfare.

Features of the program include a presentation of methods of identification of mycobacteria, drug susceptibility testing of tubercle bacilli and the effects of chemotherapy. A new film will discuss the question of why TB is not yet defeated.

For further information, write to the N. J. Tuberculosis Association at 15 East Kinney Street in Newark, or to Dr. Marvin Solomon at 119 South East Avenue in Vineland, N. J. The phone numbers are Oxford 1-9000 (in Vineland) or Market 3-4810 (in Newark). Everyone interested enough to read this paragraph is invited to attend and participate in the discussion.

Drug Safety Pamphlet Available

Now available for waiting room distribution is a neat brochure entitled *Safety of Prescription Drugs*. This explains the care taken by reputable manufacturers, practitioners and government agencies to assure that new drugs are safe. It faces up honestly to the understandable panic of thalidomide, but avoids any scare technics. Quantities of the pamphlet are freely available to you from the Pharmaceutical Manufacturers Association, 1411 K Street, N. W., Washington 5, D.C.

Locating a Blood Bank

Sometimes you may want to locate a blood bank facility in a hurry. The quickest way is to have on your desk the "Directory of New Jersey Blood Banking Facilities." This not only lists all of the blood banking resources in New Jersey, but has a map that locates them geographically and is arranged both by county and by name of the facility.

If you are interested in getting a copy of this Directory, write to the Chairman of the Blood Bank Commission at 45 South Grove Street, East Orange, New Jersey.

Catholic Psychiatric Center Now Being Built

Plans are now under way to build and staff the first national, private center of Catholic psychiatry, where a new unique effort against mental illness will be made through the "synthesis, harmonization and integration of psychiatry and religion." At Marsalin Institute in Massachusetts, coordinated programs of treatment, training and research will embrace all the social sciences, education and social case work. A Benedictine monk with an M.D. from the University of Pittsburgh (one of three known psychiatrist-priests in the Western hemisphere) has daily cared for a dozen mental patients during the last five years in a modest frame house in Massachusetts. He is Father James E. Hayden, who has practiced medicine and taught psychiatry. Speaking of psychiatry and religion, Father Hayden has said that neither alone can succeed against the

enormous problem that fills half of the hospital beds and afflicts many millions of individuals. He referred to a long felt 'urgent need" to bring together the "valid principles of a practical science" and "revealed truth concerning men's moral nature and needs and his eternal destiny." The development of this approach and its application to promote mental and spiritual health are the aims of the new center. Father Hayden states that he has seen "doubt and mistrust of psychiatry on the part of many Catholics," but "Catholic educators, psychologists, philosophers and theologians, in their attempt to understand aberrant human behavior, are increasingly turning to the field of psychiatry for enlightenment."

The new center, Marsalin, is described as a non-profit institution supported by contributions from individuals in the professions and business. It will be open to all. Father Hayden said it will provide the best available personnel in all disciplines—social workers, sociologists, anthropologists and educators, as well as psychiatrists, psychologists and theologians—regardless of background. Moreover, as facilities and staff permit, patients who have objection to treatment by Catholic staff members will be cared for by others.

Marsalin (an abbreviation for *Maria Salus Infirmorum,* "Mary, Health of the Sick") is being built on property recently acquired in Holliston, 25 miles from Boston. Up to now, it has been in Brookline and has consisted of one building where Father Hayden has carried a heavy patient load and has also maintained a worldwide correspondence.

The plans call for a center with surrounding pavilions for retarded children, disturbed children, socially maladjusted adolescents, and disturbed adults, "especially those who by virtue of their positions exercise great influence in the lives of others" or who are failing vocationally, such as business and professional people.

Marsalin will have university medical school affiliation and be organized to qualify according to the standards of the American Psychiatric Association and the American Association of Psychiatric Clinics for Children. The social case work approach will be adopted.

Radiation Equipment Survey

Some physicians have asked the State Department of Health about requirements for surveys of radiation-emitting equipment or material. Such surveys are required under the New Jersey Radiation Protection Code.

The New Jersey Commission on Radiation Protection (the official body responsible for drafting the Code) wishes all x-ray installations to be brought into compliance with the Code. Failure to have a radiation survey performed is noncompliance with the Code.

Only two per cent of machines inspected early by the State, shortly after Chapter 11 became effective, were found to be in compliance with the Code. The oldest machines were, however, deliberately chosen for earliest inspection. The rest were found to have an average of three defects per machine. Correction of defects of all x-ray installations will substantially reduce significant gonadal radiation exposure to the general population. Fifty per cent of such significant exposure is estimated to stem from medical and dental x-ray procedures.

Physicians are urged to have radiation surveys performed at an early date and to correct defects promptly.

Radiation surveys may provide some protection against malpractice suits alleging overexposure to x-rays if the survey establishes that the machine was in good working order and being properly used at time of inspection.

You may be approached by private persons who desire to make inspection surveys for a fee. Physicians interested in having a comprehensive survey by a private individual are urged to communicate with the State Department of Health (EXport 2-2131, Ext. 8282). The Department maintains a roster of persons qualified to conduct such surveys. Reports prepared by them will be accepted by the Department.

All installations must *register* with the Department. Registration is, however, not a survey as required by law.

Letters to The Journal • • •

Mene, Mene, Tekel, Upharsin

The establishment of Blue Cross Plans thirty years ago by the medical profession deprived the hospital pathologist of the control of his earnings. Some refer to this status of the pathologist as "sold down the river." Recently State Boards of Medical Examiners have barred the intern from the laboratory service. Consultants of the training program refer to the laboratory services as "non-clinical medicine."

It would appear opportune to advise the reader that despite this adverse state of affairs there are still devoted pathologists who place dedication to their profession above pecuniary matters. These scholars have continued to offer their abilities in the provision of professional services to physicians, teaching technicians, and training interns or residents.

The action of the Pennsylvania State Board of Medical Examiners in withdrawing laboratory service from a rotating internship has been followed by other states. A period of laboratory education for the intern is no longer regarded as essential to the rotating internship. Apparently mental acuity guarantees manual dexterity to all physicians. However, I personally view with genuine concern the results that could occur if such practitioners of medicine are asked to obtain a specimen of blood from the external jugular vein of an infant of three or six months of age.

Residency programs in pathology or clinical pathology have, at present, few applicants and even fewer acceptable candidates. The pathologist who accepts the responsibility of training a candidate does it without any additional financial compensation. Those who have piloted doctors through this experience will appreciate the burdensome task.

Those who "counsel" (I use this word on direct advice) the hospital concerning residency and intern programs now advise that if the program has had no incumbent in two years—("the figures being against the program")—chances of their continued approval are slim. I am personally not quite clear as to just what this has to do with the ability of any pathologist to develop and direct a residency program in pathology.

The intern learned, as a part of the organized laboratory service program, such amplifications of basic science as urinalysis, bacteriology, serology, blood typing, hematology, surgical pathology, necropsy fundamentals, and intravenous technic. The proper interpretation of laboratory results, biochemical norms, and electrolyte equilibrium could be learned by experience—(this is still an excellent master). The laboratory tour gave the pathologist an opportunity to contact the house staff to determine who had the motivation and brains (sorry, the pen slipped) of a potential candidate as a pathology resident. Without residents in pathology there can be no trained pathologists.

Who shall occupy the pathologists' rostrum in the future? Highly trained medical technicians? Microbiologists? Doctors of chemistry, biology, electronic engineers—all are standing on the sideline waiting for the call. Current advertisements read, "Pathology laboratory supervisor—man or woman—must be able to supervise ten technicians, maintain standards and organize work loads. Require B.S. degree and up to ten years pathology exp." If the reader gets the message, may I ask if this is what the medical profession really intends for the specialty of pathology? Will the resulting lowering of professional standards within the laboratory give the patient better medical care?

As of this moment no national society representing pathologists has been consulted in this marked alteration in the rotating internship program and no one speaking for the pathology profession has protested these actions of the boards of medical examiners. The Pennsylvania Society of Clinical Pathologists has approved a protest (Spring 1962 meeting). The New Jersey Society and other local and national groups who should be interested have manifested only massive inactivity.

Perhaps the presence of the pathologist is resented by the clinician, the surgeon, the internal medical man, because his activities are serving either directly or indirectly to prevent unnecessary surgery, demanding accurate diagnoses and insisting on proper patient care

even at the local level, as well as limiting unnecessary transfusions.

Is the future physician to become uninterested in the collection and study of body fluids? Shall such tasks be turned over to persons with less academic training than that of a doctor of medicine? Is it the intention of the medical profession that the inevitable lowering of standards of medical care which will result from such a program shall be considered as constituting adequate medical care for the American people?

Organized medicine has justifiably protested the King-Anderson Bill. It is our opinion that organized medicine should also vigorously protest the development of physicians who will ultimately come to medical licensure, perhaps with ample knowledge, but with inadequate capabilities to perform so much as a blood count for the sick who may seek their professional services.

Perhaps those who would destroy the private practice of medicine have decided first to eliminate the trained pathologist. History does repeat, and after thirty years organized medicine appears again to be cooperating in preventing young physicians from being exposed to the laboratory service, thereby seriously limiting the physicians who may be recruited to the specialized practice of pathology.

For the curious reader who has followed to the bitter end, may I point out that the title of this discussion is said to represent the handwriting on the wall from the first book of Daniel.

THOMAS K. RATHMELL, M.D.

Technologists and Technicians

Physicians are often asked to advise patients and friends about careers in medical technology. The wrong advice can lead to expensive training that turns out to be almost useless—since Laboratory Directors may not accept certain types of training—or may assign them to poorly paying subordinate positions.

In this connection, the following material (from *Modern Hospital*) should be of interest to our readers.

At least 16 "commercial" technical training schools have entrance and performance requirements inferior to those maintained by the AMA-approved schools. These schools, plus some "private" ones, are offering to help hospitals recruit technicians. Their terminology and insignes of some of these groups are confusingly similar to the symbols used by the Registry of Medical Technologists approved by the American Society of Clinical Pathologists. The insignes of the AMA-approved schools carry the letters: MT (ASCP) —and any other combination of letters offered by a technician should alert the physician to the *possibility* that it comes from a substandard school. Many of these inferior schools solicit students from rural areas. Tuition ranges from $620 to $1,395 cash; more, if paid by the month.

Parents signing school contracts presented by salesmen called "registrars" are often liable for one-fourth of the total tuition in some cases even if the student never goes to school after making the down payment.

An estimated 1,500 men and women graduate from the commercial medical technologist schools each year. Some schools claim 6,000 graduates over a period of years. These commercial schools require high school graduation "or its equivalent." In some schools the "equivalent" seems to mean that the student has enough money to meet the tuition, The *Modern Hospital* article says.

Qualified medical technologists with the degree MT (ASCP) must have three years of college plus a fourth year of clinical training in a hospital school of medical technology headed by a pathologist and approved by the American Medical Association. Board examinations are given semi-annually for this degree by the Registry in Muncie, Indiana.

National interest in adequate training for medical technologists is fostered by the *National Committee for Careers in Medical Technology*, 1785 Massachusetts Avenue, N. W., Washington 6, D. C., an organization sponsored by the American Society of Medical Technologists, the American Society of Clinical Pathologists and the College of American Pathologists. This committee has representatives in New Jersey who cooperate with the medical and hospital professions. In addition, the committee gives certificates of merit at regional high school science fairs and at the National Science Fair International. For further information, write to Dr. Joseph P. Greeley, 925 East Jersey Street, Elizabeth.

County Society Reports • • •

Burlington

Breaking with tradition, the *Burlington County Medical Society* held its first straight business meeting on June 14, at Millside Farms Dairy Bar, to wind up business prior to our summer recess. Dr. Lindley B. Reagan, incoming president, was chairman, with 42 members present.

The membership was advised that malpractice rates would be increased and that it would be 18 months before rates would be reviewed again. Use of AMA medico-legal forms was also emphassized. The secretary, Dr. Amy Barton, reported on the Society's efforts to publicize the differences between the King-Anderson and the Kerr-Mills bills, and offered speakers' kits on medical care for the aged and choosing medicine as a career. Present society membership stands at 137.

One of our state delegates, Dr. William E. Bray, gave a synopsis of activities at the annual meeting regarding the stand of various reference committees on legislation before the state assembly.

The following were elected to membership: Drs. John N. Burke, transfer from Associate to Regular; James K. H. Young, transfer from Medical and Chirurgical Faculty of Maryland; William A. Kemick for Associate and Stanley C. Leonberg for Courtesy membership (regular membership in Camden County).

A discussion was held about oral poliomyelitis vaccine by mass immunization. The reasons "pro" were detailed by Martin Goldfield, M.D., Virologist with the State Department of Health. A letter from the Moorestown General Practitioners and Pediatricians Association was read by Edmond Preston, M.D., supporting this project. It was decided that the Society would release a statement to the press affirming its stand so that the physicians of the county would lead in this crusade, although its implimentation will depend upon assistance from lay organizations.

It was voted to accept advertising in our county bulletin to defray the cost of printing. If sufficient, excess revenue will be used to help offset other county society expenses.

Meeting was adjourned for a social hour with refreshments.

THOMAS E. MATTINGLY, JR., M.D.

Reporter

Mercer

Installation of the following officers for 1962-63 of the *Mercer County Component Medical Society* took place at the Trenton Country Club on May 9: *President*, Herbert M. Wolff, M.D.; *Vice-President*, Henry L. Drezner, M.D.; *Secretary*, Joseph M. Fiorello, M.D.; *Treasurer*, William H. Coleman, M.D.

John J. Calabro, M.D., Assistant Professor of Medicine of Seton Hall, spoke on "Common Problems of the Feet,"

The annual outing was held on June 14 at the Trenton Country Club. Distinguished guests included the Mayor of Trenton, Arthur J. Holland; and representing the Medical Society of New Jersey were Louis S. Wegryn, M.D., President; Ralph M. L. Buchanan, M.D., Past-President; and Richard I. Nevin, Executive Officer. Highlighting the outing were the golf, tennis, and quoit tournaments, as well as many prizes.

Newly elected members of the Society for the months of April, May and June include: *Associate membership*: Drs. Rufus W. Miller; Peter Amadio, Jr., Frank A. Clair. *Transfer of Active memberships*: Dr. Willard Delrymple, from Charles River (Massachusetts) Medical Society. *Advancement from Associate to Active membership*: Drs. Frank Campo, Thomas L. Evans, John C. Freda.

JOSEPH M. FIORELLO, M.D.

Reporter

Middlesex

Our annual dinner meeting, with election and installation of 1962-1963 officers, at the Greenbrier Restaurant, North Brunswick, on Wednesday, June 20, was its usual well-attended and gala affair.

After cocktails and an excellent dinner, Dr. Thomas F. McLaughlin, president, called the assembly to order for the regular business meeting. A moment of silent prayer was offered for our departed colleagues—Dr. S. Gordon Berkow, Sidney D. Becker, Charles Taber, and Edward F. Klein.

Dr. B. F. Slobodien, chairman of the Judicial-Medical Ethics Committee, presented the following Credentials Committee-approved applications for admission to the Society: by transfer from

Essex County Medical Society, Dr. Paul Drucker, Fords, to two years Associate membership; Drs. Daniel P. Schoicket and John Neil Kennedy to Regular membership from two years Associate membership; also, by transfer from Kings County Medical Society, Dr. Richard S. Schlesinger, to regular membership.

The following members, having retired from active practice, were elected to Honorary membership: Drs. Harold W. Potter of Metuchen and Joseph S. Mark of Woodbridge. Resignations of Drs. Martha F. Leonard and Hugh Williams of Highland Park were accepted.

Dr. Charles H. Calvin, chairman of the Constitution and By-Laws Committee, presented two amendments to the Constitution and Bylaws. After considerable discussion they were accepted, as follows:

Amendment to Constitution—Page 13: Article VI—Board of Trustees—Section 1—Number of Trustees. "There shall be a Board of Trustees consisting of fifteen (15) active members in good standing, of the Society."

Amendment to the Bylaws—Page 42: Article V—Board of Trustees—Section 3—Duties. (On page 29, add paragraph "G"). "The Executive Committee—The President, Vice-President, Secretary, Treasurer, and Reporter, and the Chairman of the Board of Trustees shall compose the Executive Committee. It shall act on emergency measures when time does not permit a meeting of the Board of Trustees. Any action thus taken shall be subject to formal action of the Board of Trustees at its next meeting."

Dr. George Henderson sparked a move to eliminate as much business as possible from the "annual dinner" meeting. However, in view of our long history of such procedure, it was felt better not to change during this meeting. I'm sure the discussion gave many members food for thought, and perhaps at a later meeting this will be discussed.

Dr. Charles Gandek presented the new fee schedule for office visits and house calls: five dollars ($5.00) and seven dollars ($7.00). Placards are to be printed and submitted to the membership for office display.

Dr. Donald T. Akey, chairman of the Public Relations Committee, had a most active year. The Society is grateful to him for his outstanding performance. His resolution to improve our position in the public eye was tabled for further discussion.

Dr. John Albert Smith, chairman of the Nominating Committee, presented the following officers, *etc.*, for the coming year; with the Secretary casting the ballot this slate was accepted unanimously:

President, Dr. Ralph E. Siegel, Perth Amboy; *Vice-President*, Dr. Rudolph G. Matflerd, New Brunswick; *Secretary*, Dr. Albert S. Basri, Colonia; *Treasurer*, Dr. Eugene J. Tyrrell, Perth Amboy; and *Reporter*, Dr. Eugene L. Childers, Nixon. The following were elected as members of the Board of Trustees: Dr. Thomas F. McLaughlin, chairman; Drs. Charles H. Calvin, Stanley A. Gadek, Charles Gandek, Gerard R. Gessner, George J. Kohut, William G. Kuhn, A. Marshall Smith, Sr., John Albert Smith, and B. F. Slobodien.

Delegates and Alternates, with term expiring in 1964: Drs. R. Levinson—Cyril I. Hutner; Charles H. Calvin—L. A. Perillo; Albert Schwartz—Morton M. Klein; Gerard R. Gessner—Joseph T. Lang; Sol Gurshman—Eugene L. Childers; Howard D. Slobodien—Gerard J. Aitken; Ralph E. Siegel—Edward Jasionowski; A. J. Barbano—Harold B. Fein; Charles Gandek—Victor Boogdanian.

Delegate and Alternate to 1963 State Medical Society Medical Society Nominating Committee: Drs. Charles H. Calvin and Gerard R. Gessner.

After Dr. McLaughlin's farewell address, he was presented with a past-president plaque by Dr. Siegel. Dr. Siegel, on presenting the plaque, expressed the feelings of the Society when he stated "Doctor McLaughlin has had a most successful year in the face of many difficult problems and decisions."

Dr. Ralph E. Siegel, newly-elected president, then gave an extremely energetic and enthusiastic acceptance speech.

The Society is looking forward to another very interesting and productive year.

EUGENE L. CHILDERS, M.D.

Reporter

Morris

The regular monthly meeting of the *Morris County Medical Society* was held on June 21 at the Rockaway River Country Club. Forty-eight physicians participated in the Golf Tournament held prior to the meeting. The winner of the Low Gross Trophy, with a score of 76, was Dr. Robert Mulholland.

Dr. Dexter Blake, the outgoing president, received warm words of praise from the incoming president, Dr. Daniel Melvin. In addition, he was presented with a gavel token for his service during the year of 1962. Dr. Louis Wegryn, president of the State Medical Society, was the honored guest and presented the greetings of the State Society. The barbecue was heavily attended and thoroughly enjoyed by all the membership.

MONROE H. MUFSON, M.D.

Reporter

Obituaries • • •

DR. CHARLES BERGEN

Dr. Charles Bergen, a Middlesex County general practitioner, died at his home in Spotswood on August 21. Born in 1899, Dr. Bergen received his M.D. at Cincinnati in 1929. After completing his internship, he did general practice for a decade and then entered the medical corps of the Army of the United States. He rose to the rank of major and received several citations. After being demobilized, he came to Spotswood to return to private practice. Dr. Bergen was a member of the International Academy of Proctology and was active in the affairs of the Middlesex County Medical Society.

DR. JOHN D. CAGGIANO

At the untimely age of 53, Dr. John D. Caggiano died in Wilmington, Delaware, on August 6. A Penns Grove general practitioner, Dr. Caggiano had been graduated in 1934 at the Hahnemann Medical College. Coming to Penns Grove to intern at the Memorial Hospital there, he made Salem County his home and served the people of South Jersey as a family doctor from 1935 until he was disabled by his final illness in January 1962. He was affiliated with both the Memorial Hospital and the Salem County Hospital. A director of the Penns Grove National Bank, Dr. Caggiano was active in civic affairs in Salem County.

DR. ISAAC N. GATTO

Dr. Isaac N. Gatto, medical director of the Fairlawn Memorial Hospital, died suddenly on July 22. A board diplomate in Obstetrics and Gynecology, Dr. Gatto was a 1923 graduate of the University of Naples. He saw service as a major in the medical corps of the Army of the United States during the second world war. Dr. Gatto was professor of gynecology at Polyclinic Hospital in New York City, and senior obstetrician to the Columbus Hospital there. He was 59 years old at the time of his death.

DR. BERNARD GREENFIELD

One of the pioneers of Essex County medicine died on July 1 with the passing that day of Dr. Bernard Greenfield. Born in 1877, he earned his M.D. at New York University in 1898. He was a co-founder of the Newark Beth Israel Hospital and had a long period of service as a chief of surgery there. A member of the New Jersey Society of Surgeons, he was also an FACS. Dr. Greenfield retired from active practice in 1958 and lived in retirement in Florida for the following years.

DR. GUIDO GUIDI

A moving saga of courage and service came to an end on September 5 with the death that day of Dr. Guido Guidi. Dr. Guidi lost one eye in an automobile accident in 1920; and an inoperable cataract robbed him of vision in the other eye in 1940. Yet he practiced for years after that, apparently not seriously handicapped by this disability.

Born in Italy in 1876, he received his M.D. at the University of Naples in 1900. In 1905 he came to the United States, settling in Elizabethport. Though he always considered himself a family doctor, he became increasingly interested in obstetrics and delivered more than a thousand babies in the period between 1910 and 1948—when he stopped counting. In 1957 he was a laureate of the Golden Merit Award of The Medical Society of New Jersey. Dr. Guidi was active in and for some years had been an emeritus member of that component.

DR. CARL G. KAPP

While treating a patient in the emergency room of the Elizabeth General Hospital, Dr. Carl Kapp suddenly suffered a fatal coronary attack on June 26, 1962. Born in Pennsylvania in 1903, Dr. Kapp received his baccalaureate degree at Bucknell in 1924 and his M.D. at Jefferson Medical College in 1928. After a brief period of general practice, he did graduate work in ophthalmology. A board diplomate in that specialty, he was formerly chief of staff at the Newark Eye and Ear Infirmary. He also had a tour of duty as president of the Union County Medical Society, and as chief of staff at Elizabeth General Hospital.

DR. IMRE KEMENY

One of Middlesex County's senior general practitioners died on July 6 with the passing that day of Dr. Imre Kemeny. Born in Budapest in 1892, he received his M.D. at the University there in 1916. After the termination of the first World War he came to New Jersey and settled in Carteret, whose people he was to serve for almost half a century. He was a family doctor, actively affiliated with both the Rahway and Perth Amboy hospitals.

DR. JOSEPH S. MARK

Former chief of staff at the Rahway Memorial Hospital, Dr. Joseph Sidney Mark died on September 5 at that hospital at the age of 69. Born in Hungary, he came to the United States in 1906, entering Bellevue Medical School in 1910. earning his M.D. in 1914. After interning at the Elizabeth General Hospital, he entered the Army of the United States, serving in the medical corps during World War I. He then came to Woodbridge and served the people of that area during the ensuing 45 years. He had a tour of duty as president of the Middlesex County Medical Society. Dr. Mark also served as medical director of the U. S. Metals Refining Company. Though he concentrated largely on surgery in his private practice, Dr. Mark was also a recognized authority in the field of industrial toxicology, particularly lead poisoning.

DR. CORNELIUS McCARTHY

One of Sussex County's leading practitioners, Dr. Cornelius McCarthy, died July 30 at his home in Sparta. Born in Bayonne in 1903, he received his baccalaureate degree at Villanova and his M.D. at Louvain (Belgium) in 1933. After an internship at New York's St. Vincent's Hospital, he did graduate work at Michigan in cardiovascular disease. Dr. McCarthy was a Fellow of the American College of Cardiologists, a former president of the Sussex County Heart Association and consultant cardiologist at the St. Francis Hospital in Jersey City, as well as to the Medical Center there. He served a year as president of the Bayonne Lions Club and was active in school medical services in Sussex County. He was Attending Physician at the Memorial Hospital in Newton.

DR. ERIC J. RYAN

Death came on July 12 to Dr. Eric J. Ryan, one of Bergen County's best known radiologists. Born in Canada in 1897, Dr. Ryan received his M.D. at McGill in 1921. He came to New York for graduate work in the then young specialty of radiology, eventually becoming senior roentgenologist to St. Luke's Hospital there. After 13 years of that service, he was commissioned in the medical corps of the U. S. Navy where he served throughout World War II. Dr. Ryan became a diplomate in radiology and roentgenology. After his war service he came to New Jersey, becoming chief radiologist at the Hackensack Hospital and director of radiology at the Valley Hospital in Ridgewood. Dr. Ryan was active in the American Roentgen Ray Society as well as in the Radiologic Society of North America.

DR. LEE SOLWORTH

One of Bergen County's most active practitioners, Dr. Lee Solworth, died on August 21. Born in 1909, he received his M.D. at Bellevue in 1934. After interning at the Jersey City Medical Center, he devoted several years to teaching at his alma mater and then came to Englewood for private practice. Dr. Solworth limited his practice to surgery. He was president of the Englewood Board of Health, and physician to New Jersey's State Athletic Commission. He was director of the surgical clinic at the Englewood Hospital, and active in the affairs of the Bergen County Medical Society, and of the American Legion.

November — Life Month

Life Month for the life insurance plan endorsed by our State Society begins November 1 and ends November 30. During this month, members under age 65, not yet covered by the plan, may apply—subject to company approval of their applications—for from one to five $10,000 units providing a maximum coverage of $50,000 (double indemnity and waiver of premium are included).

At present, nearly 1800 members are insured under this plan; and they may apply to increase their present coverage to the maximum of $50,000, subject to a physical examination at company expense by a local examiner. To date, claim benefits to beneficiaries totaling $450,000 have been incurred.

You may continue to renew your policy for further five-year periods beginning before age 65. Your individual term policy may be converted—at any time—to permanent life insurance without physical examination or further evidence of insurability.

Our Society's plan, at lower premiums than comparable policies obtained individually, may be retained even if you retire or move from New Jersey. Current annual dividends are: $14 under age 40; $10 for those age 40 to 49; and $6 for those age 50 to 59. Now is the time to provide for your family the additional protection they will need. Your next opportunity to participate will be November, 1963.

Members will receive complete information from the administrator, E. and W. Blanksteen Agency, Inc. during *Life Month*. The address is: 75 Montgomery Street, Jersey City 2, N.J.; the tlephone number is: DElaware 3-4340.

By Committee on Medical Defense and Insurance
D. F. FEATHERSTON, M.D., CHAIRMAN

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Medical Physiology. Edited by Philip Bard, M.D. St. Louis 1961, Mosby. Ed. 11. Pp. 1339, with 508 illustrations. ($16.50)

Since 1918, this book in its preceding editions has been a solid reference work to generations of students. The current, eleventh edition, is an anthology written by a star-studded faculty, led by Johns Hopkins' distinguished professor of physiology. Some of the biochemical material discussed in earlier editions has been deleted. There is a new chapter on the physiology of exercise. In most of the chapters, an additional dimension is given by a review of the historical background of our knowledge. Almost unique is the well presented material on cardiodynamics, resting potentials, and the physiologic effects of high altitude.

In style, the book is uneven, as one might expect from the combined efforts of 16 different authors. Most of the chapters are written at a straight, no-nonsense, pedestrian pace, which makes the book more suitable for reference than for systematic study. But, all in all, it is an authoritative volume, covering the physiology of circulation, fluid regulation, alimentation, metabolism, endocrine gland action, respiration, neuromuscular activity, vision, hearing and chemical sense.

Ulysses Frank, M.D.

Problems in Surgery. By Frank Glenn, M.D. and G. E. Wantz, Jr., M.D. St. Louis, 1961. Mosby. Pp. 512 (with 263 illustrations). ($16.50)

This publication arises from the department of surgery of the New York Hospital (Cornell Medical Center). It comes largely out of their weekly grand rounds. At these sessions, cases are presented illustrating special or recurrent problems in diagnosis and treatment, general principles of surgical management, methods of pre-operative and postoperative care, and the relationships among surgery and the other basic and clinical disciplines. The discussions are frank and unrehearsed. Complications and failures are not overlooked since as the authors state "from meticulously honest and thorough consideration of these cases much may be learned both by the novice and the veteran."

The group contributing the material includes senior members of the general surgical staff, plus representatives of eight surgical specialties. Doctors from the departments of anesthesiology, medicine, pathology, pediatrics and radiology, as well as distinguished visitors from all parts of the world, contribute to the discussions.

The material was edited from tape recordings made at the time of the discussion. The presentations are remarkably brief considering the magnitude of the problems covered. Following the resident's presentation of the case, the radiologic findings and laboratory material are reviewed; and then ensues a discussion of the problem, moderated by the professor (Dr. Frank Glenn).

It would be difficult to think of a problem in the entire field of surgery which is not touched upon in this treatise.

The clarity of presentation makes this a valuable adjunct to the surgeon's library for rapid reference, and narrated opinion. Each case presentation is followed by several references for expansion of the problems presented. A further asset of the case presentations is that they are devoid of academic discussions of the subject and the opinions applied to the specific case under consideration.

D. F. Featherston, M.D.

Problems of Pulmonary Circulation. (Ciba Foundation Study Group No. 8). Boston, 1961. Little & Brown. Pp. 96, illus. ($2.50)

The reality of cardiac and thoracic surgery and their spread to even the smallest of well-equipped general hospitals make it necessary for the doctor to have a fundamental and working knowledge of the chest and its contents. This booklet (the record of the proceedings and discussions of 25 prominent cardio-pulmonary workers) goes far toward making the gathering of this information a pleasant task.

In this volume, pulmonary circulation receives special attention. It is studied from radiologic, isotopic, physiologic, anatomic and clinical points of view. Congenital and acquired defects of the circulation and their effects upon this system are assessed. The discussions by the participants following the reading of papers on the subdivisions of the study are particularly enlightening.

The booklet apparently has been prepared for clinicians. The illustrations and tables are timely and well reproduced. The work is extremely readable and should be a welcome addition to every physician's library.

George E. Gittens, M.D.

Eye Symptoms in Brain Tumors. By Alfred Huber, M.D. Translated from the German by Syefan van Wien, M.D. St. Louis, 1961, Mosby. Pp. 329 with 192 illustrations. ($16.00)

This interesting book is based chiefly on the personal experiences of the author in the Neurosurgical Clinic of the University of Zurich. It is an eminently practical volume. Its many important presentations are usually accompanied by clear explanations of their anatomic and physiologic bases.

In additional bolstering of his presentation, Dr. Huber makes reference to many articles and books. The arrangement of the bibliography is excellent and would be most useful for one fluent in German. Dr. Huber's book contains many facts and concepts which should be familiar to the ophthalmologist and the neurologist. Bringing together of all these in one compact volume does a great service .

The initial section on methods of examination and history-taking is presented in great detail and is of much value. I found the subsequent sections (general symptoms, local symptoms of brain tumors; relationship between the type of tumor and ocular symptomatology; and pseudotumors, including aneurysms) to be very well done, each more fascinating than the preceding section. Here, in short, are the important facts on eye symptoms and signs in brain tumors, written clearly, completely and interestingly.

S. Jerome Greenfield, M.D.

Biologic Activity of the Leucocyte. (Ciba Foundation Study No. 10). Edited by G. E. Wolstenholme and Maeve O'Connor. Boston, 1961. Little, Brown and Company. Pp. 120, with 17 illustrations. (Price not stated)

This volume discusses leukocytic function in tissues, immunologic activity of lymphocytes as well as non-immunologic activity. The metabolic shifts of leukocytes during phagocytosis are studied as well as the pattern of leukocytosis, and the energy levels and metabolism of the white cell inside and outside the blood stream. Following each presentation, there is a notation of general discussion remarks by the members of the symposium.

The reviewer is somewhat confused by the fact that the presentation deals with ultra-metabolism of the leukocyte while the major discussion of the group following the final presentation vacillates between what was originally discussed and the immunologic factors involved in the taking of a skin graft. The discussers air numerous unproved concepts, readily admitting their fanciful ideas.

"During the synthesis of antibody, the lymphocytes metamorphosed to plasma cells through intermediate cell forms." Gowans states: "The intravenous injection of normal or sensitized isologous thoracic duct cells leads to the destruction of long-established homografts of skin in immunologically tolerant rats," believing that "It is probably the small lymphocyte which initiates the graft-against-host reaction." Yoffey writes that the "red cell production is markedly stimulated during primary hypoxia, almost suppressed during rebound, and powerfully stimulated once again during secondary hypoxia." Karnovsky concludes that "Phagocytosis requires the expenditure of metabolic energy on the part of the leucocyte. In the polymorphonuclear leucocyte this energy derives entirely from glycolysis" and this "provides a means for the cells to get rid of much of the protoplasmic breakdown product produced by the lytic enzymes." Vannotti points out that "glycolysis is greater in the polymorphonuclear neutrophil than in the lymphocyte. The respiration of the neutrophil is more intense than that of the lymphocyte. The proteolytic capacity, the lipase and the Beta-glucuronidase activities are higher in the neutrophil than in the lymphocyte." He further states that "the eosinophil differs from the neutrophil by a diminution of oxygen consumption and proteolytic capacity." Antonioli stresses that "the metabolic behaviour of the same type of cell is often different according to its origin." Karnovsky, quoting the experiments of others, says that the idea that red cells contribute lipid substances or lipoprotein substances to the plasma lipoprotein is probably incorrect, but that this material could arise from white cells and platelets, although the platelets are not very active.

The volume will be of major use and interest to people who are working in cellular metabolism and immunology. It will have little general appeal.

Thomas K. Rathmell, M.D.

Pathologic Physiology. Edited by W. A. Sodeman, M.D. Philadelphia, 1961. Saunders. Ed. 3. Pp. 1182 with 194 illustrations. ($15.00)

The reception given to the two earlier editions of *Pathologic Physiology* make any additional praise unnecessary. In this 1961 edition, new or generously revised chapters have been provided in such fields as genetics, neurologic disorders, protective mechanisms in the lungs, electrolyte metabolism and the physiology of the gall bladder and pancreas. There are general chapters on disease etiology, genetics, infection, toxic and traumatic agents, and the like. Then there are specific chapters dealing with each body system or disease group, including a meticulous survey of underlying physiologic factors. Each chapter is written by an expert, so that the book is an anthology. And like all anthologies, it is uneven. Some of the chapters are laden with theoretical concepts that make them hard to read. Some are as clear as crystal. Some are filled with broad generalities. Some are specific. Taken all in all, however, this is an almost unique work, bridging the gap between pathology and physiology.

Abraham Leff, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

OCTOBER, 1962 • VOL. XXXV, NO. 8

CHRONIC BRONCHITIS: A FIVE-YEAR FOLLOW UP

When the fate of chronic bronchitic patients was traced five years after first diagnosis, it was found that the number of deaths was twice that expected. The excess mortality was due primarily to respiratory diseases. Deaths due to circulatory conditions were also excessive.

Many aspects of the natural history of chronic bronchitis have been subjected to scrutiny, but little attention has been paid to prognosis in terms of life expectancy. From the clinical standpoint, a knowledge of the likely outcome for individual patients is most desirable and, as in other potentially fatal maladies, this may conveniently be expressed in terms of five-year survival.

In this study the fate of a group of bronchitic patients of different ages and with varying severity of symptoms was sought after a lapse of five years. Their clinical state was assessed at the beginning and end of the period, and the number of fatalities and causes of death was determined as far as possible.

The series consists of 312 civil servants, mostly clerical workers, messengers, attendants, and industrial workers, who attended the Bronchitis Clinic of Brompton Hospital during the period from March, 1951, to September, 1953.

The initial selection was based upon sickness records, which showed either three absences from work during one year with a diagnosis of bronchitis, or two such absences, each lasting more than two weeks.

COUGH AND SPUTUM

The criteria for acceptance were cough and sputum for at least a year, though not necessarily continuous, which could not be attributed to any other important or precipitating disease of the respiratory, cardiovascular, or other systems. Disability from either breathlessness or recurrent infections was the rule, the method of selection being such that patients were called for interview as soon as they were observed to be having repeated sickness absences from bronchitis.

Altogether, 398 such patients were referred to the clinic. A full questionnaire, including history, physical examination, and roentgenograms of the chest, was completed in 312. At the end of five years, the survivors were recalled for a second clinical and roentgenographic examination.

Seven of the patients were untraced. Of the remaining 305, 96 had died at the end of five years, the certified cause of death being known in 92. The cause used in the analysis was the underlying cause which started the chain of events leading to death rather than the ultimate mode of dying. The greatest number of deaths was due to respiratory causes, a total of 57. The underlying cause of death in each of the 57 appeared to be bronchitis and/or emphysema. Cor pulmonale was listed in seven.

Cancer was responsible for seven deaths and diseases of the circulatory system for 18. The other deaths of known cause were due to cerebral vascular accidents (three) and motor accidents and a variety of other conditions.

V. C. Medvei, M.D., and Neville C. Oswald, M.D., *Thorax*, March, 1962.

Two hundred and eighty of the patients were men and 25 were women; 77 per cent of the men were between the ages of 45 and 64.

DEGREE OF BREATHLESSNESS

The clinical assessment at five years was compared with the degree of breathlessness at the patient's first interview.

Degrees of breathlessness were defined as *mild*, meaning no breathlessness or only at heavy work; *moderate*, meaning capable of light work, breathless on walking quickly or hurrying, able to climb 12 stairs without undue distress; *severe*, meaning capable of sedentary work, breathless on walking at moderate speed on the flat or climbing 12 stairs, or greater degrees of breathlessness.

The assessment of "same, better, or worse" was based on breathlessness only. Of the 305 patients followed for five years, 136 had mild, 95 had moderate, and 74 had severe breathlessness.

The proportion of patients in whom breathlessness was the same or improved was directly related to age and to severity of symptoms at the first interview, except in the age group 60 to 74, in which the moderately breathless fared rather better than the mildly breathless.

The gradient of mortality is steepest in the younger patients, becoming progressively less steep in the two older groups (50 to 59 and 60 to 74). The serious prognostic significance of severe breathlessness in young patients clearly is seen when their mortality is compared with that of older patients with milder degrees of breathlessness.

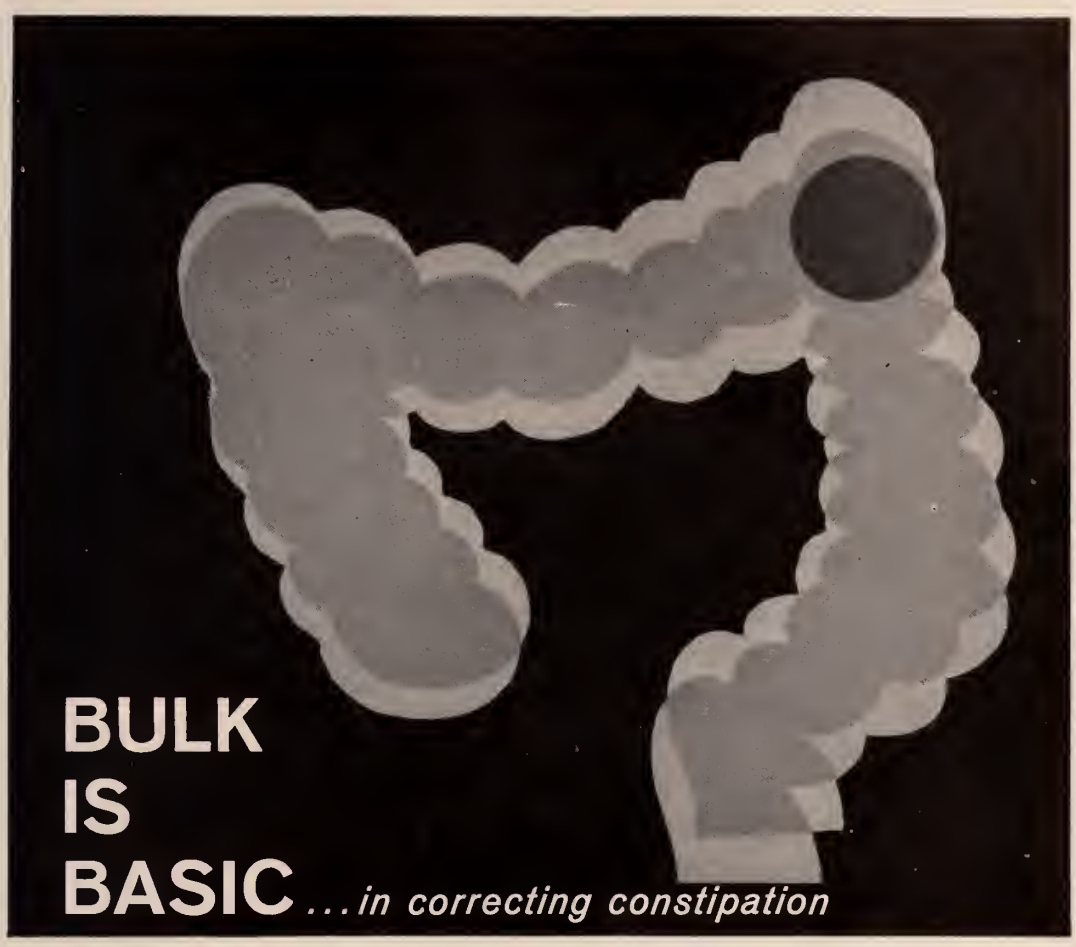
RATIO OF OBSERVED-EXPECTED DEATHS

The ratio of observed to expected deaths in this survey was 4:2 in men, 3:3 in women. The respiratory and circulatory deaths together account for the excess mortality. The excessive number of circulatory deaths must be accepted as significant.

The ratios of observed to expected deaths fell with increasing age, a fact not easily explained. They suggest that bronchitis of sufficient severity to cause sickness absences runs a more rapidly progressive course in young adults than it does in later life, and the five-year death rate of 38 per cent for severely breathless bronchitics under the age of 50 is ominous.

The general pattern of clinical status after five years is to be anticipated. The proportion of patients in whom breathlessness was the same or better declined with advancing years and the death rates increased. A moderately breathless bronchitic in the fifties was found to have a roughly equal chance of being the same or better, worse or dead, after five years. These figures may then be taken in conjunction with the causes of death which suggest that, should he die, he has roughly an 80 per cent probability of dying from a respiratory or circulatory cause.

New Jersey Tuberculosis and Health Association
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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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* * *

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	Quantity	Figure Control Calories	"Regular" Food Calories
Apple-Grape Drink	½ cup	20	52
Five-Fruit Juice Breakfast Drink	½ cup	20	52
Braised Beef and Vegetables	6½ oz.	184	380
Meat Balls in Brown Gravy	3½ oz.	84	280
Chopped Chicken Livers	1 oz.	31	100
Chicken a la King	3 oz.	72	230
French Style Dressing	1 tbsp.	10½	60
Brown Gravy	1 tbsp.	7	21

	Quantity	Figure Control Calories	"Regular" Food Calories
Applesauce	½ cup	48	90
Fruit Cocktail	½ cup	44	90
Cherry Pie Filling	1 oz.	20	60
Chocolate Topping	1 tbsp.	8	63
Preserves (Peach, Strawberry)	1 tbsp.	9	55
"Maplette" Syrup	1 tbsp.	9	55
Liquid or Powder Sweetener	(to equal 1 tbsp. of sugar)	0	16



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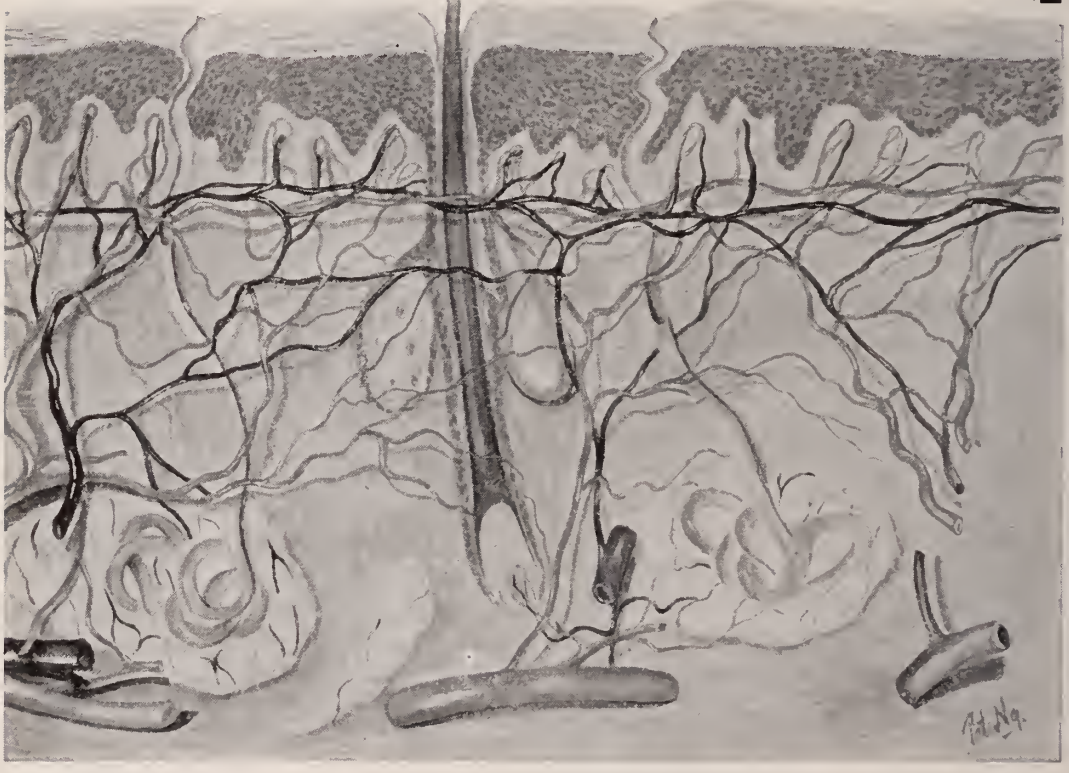
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Secret of the party trick: Interlock fork and spoon with two inner prongs of fork in bowl of spoon. Force flat toothpick between second and third prongs and place on rim of glass. Move toothpick until you find point of balance. Then burn toothpick from both ends; balance will continue.

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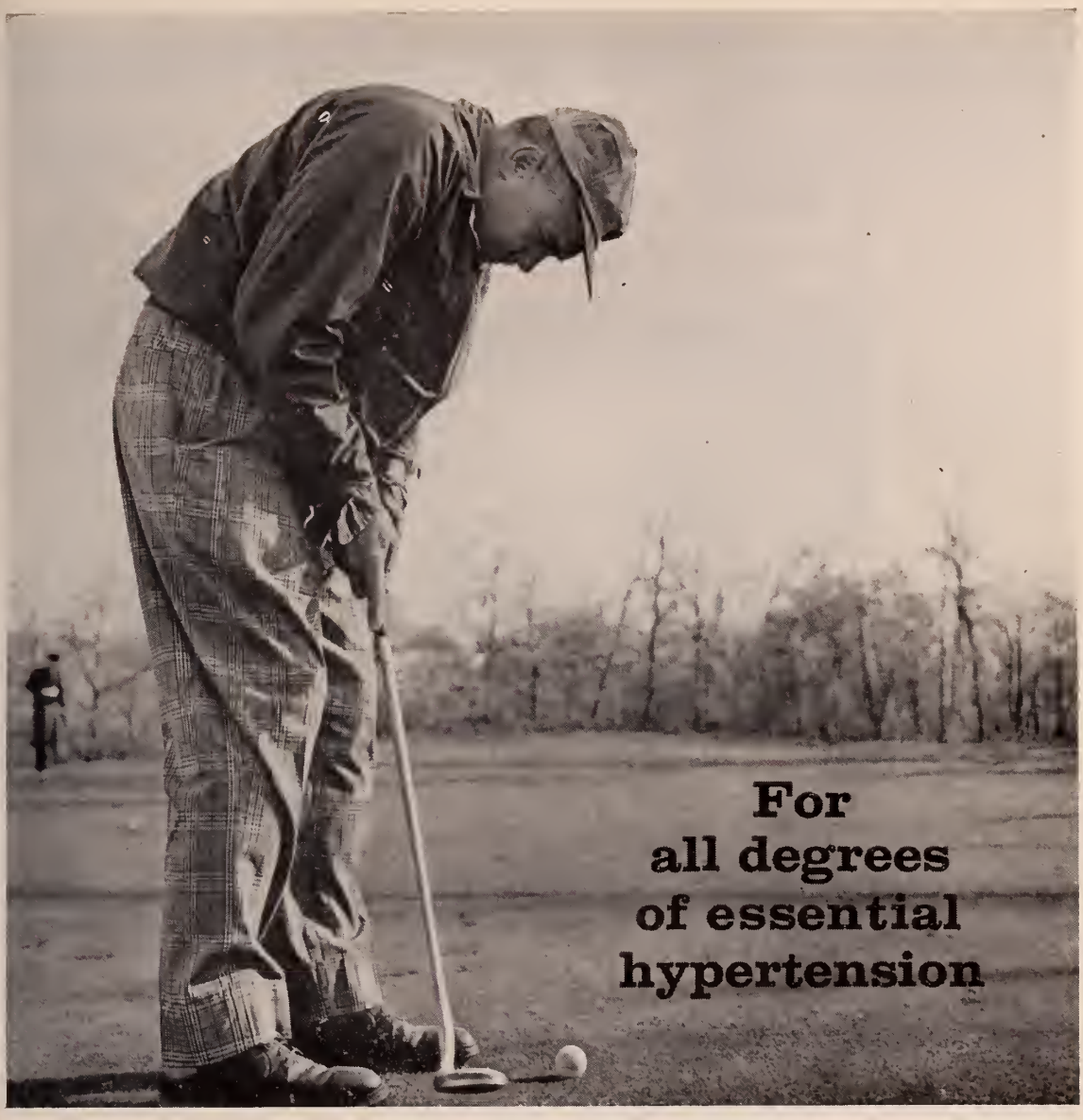
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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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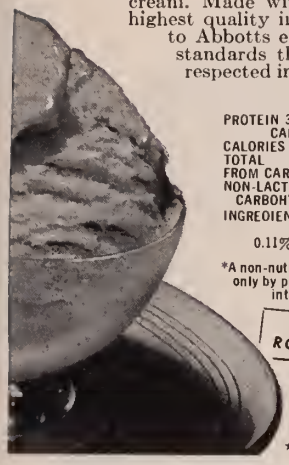
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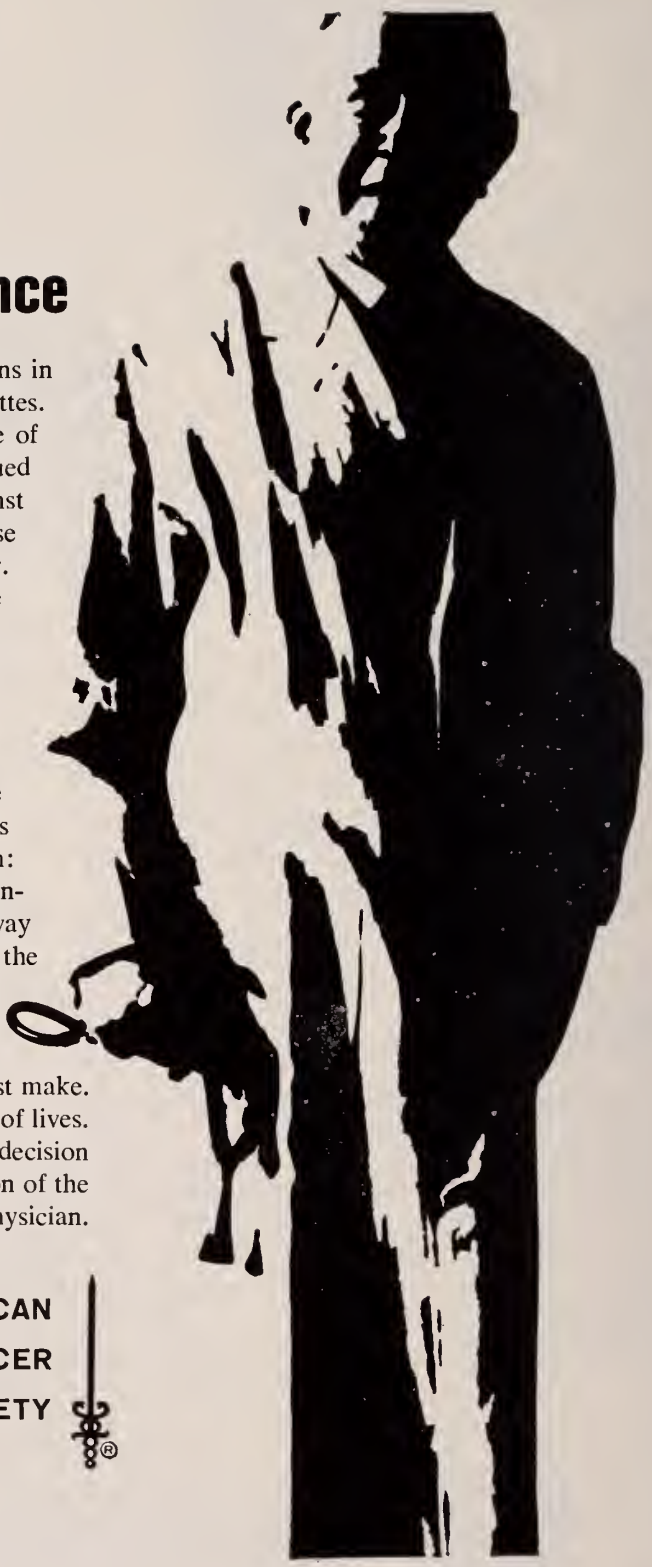
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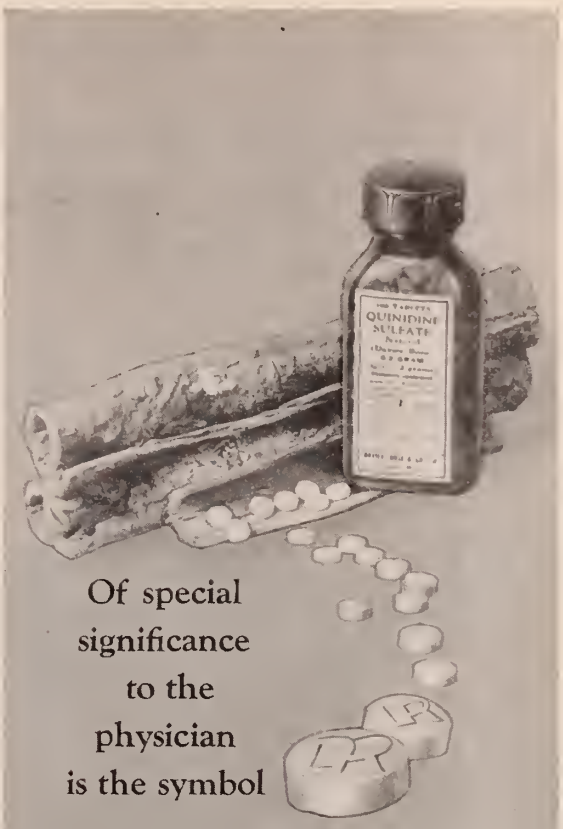
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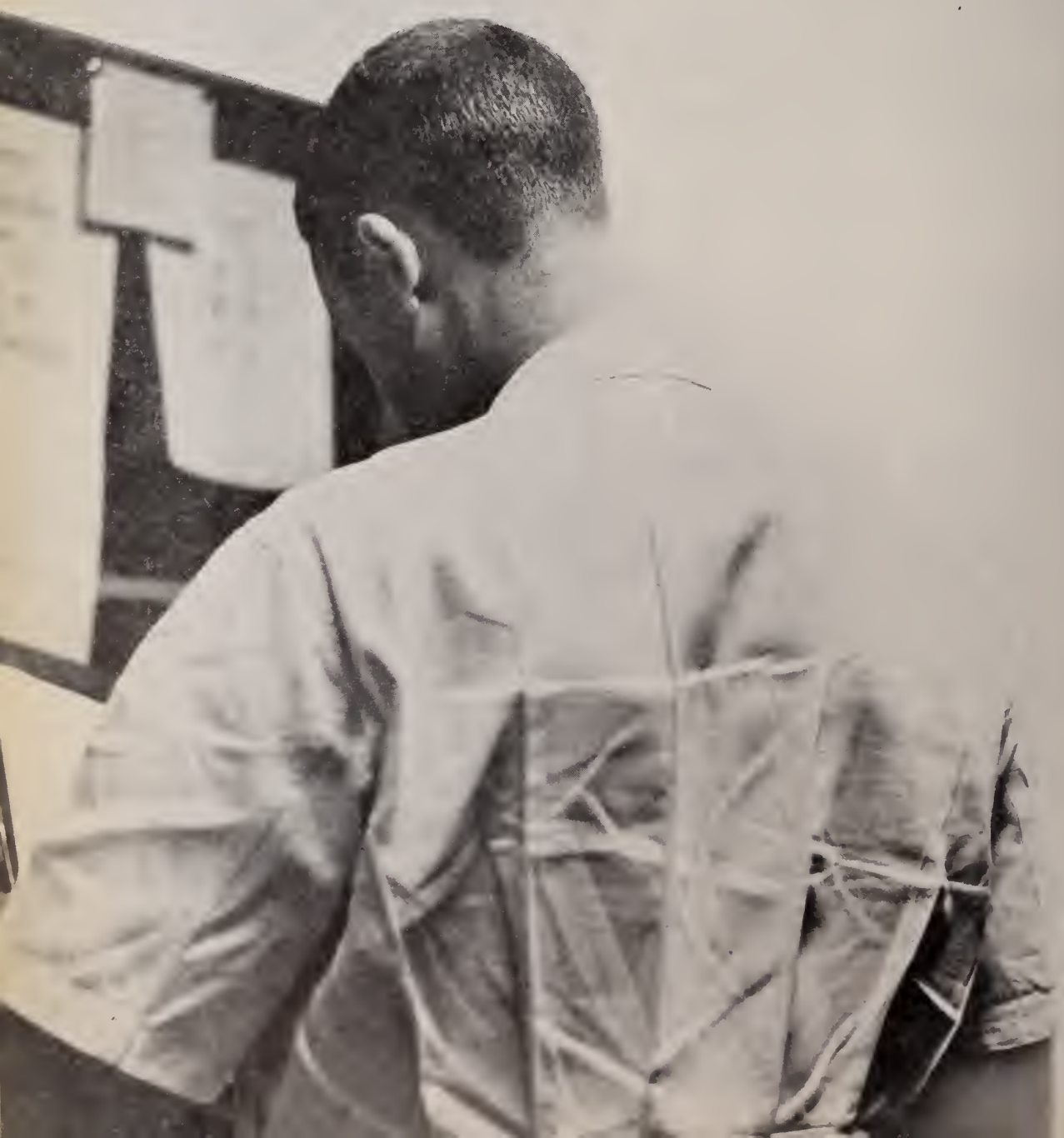
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References: (1) Katz, Y. J., & Bourdo, S. R.: *Pediat. Clin. North America* 8:1259, 1961. (2) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Whitaker, L.: *Canad. M. A. J.* **84**:1022, 1961. (6) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959.

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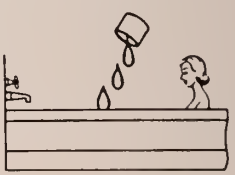
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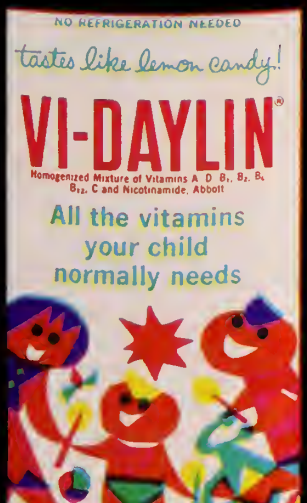
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New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

New ISUPREL® compound ELIXIR

Winthrop LABORATORIES
New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.



DANGER SIGNAL

At the first sign of the angina seizure your patients can get fast relief with a single capsule of NITROLEASE, the unique, longer-protective form of nitroglycerin.

Each 2½ mg. capsule contains hundreds of microdialyzed pellets which release the drug, immediately on contact with moisture, from the mouth throughout the entire G.I. system . . . and benefit continues for 10 to 12 hours.

DIFFUSION versus DISINTEGRATION Unlike most other "long-acting" drugs, which work basically on a disintegration principle, NITROLEASE pellets are coated with a dialyzing membrane of precisely controlled permeability to assure consistently reproducible results, rate of release being independent of pH, enzymic activity and agitation.

For more uniform control of angina patients, specify

NITROLEASE*

Microdialyzed pellets of nitroglycerin

INDICATIONS: Prophylaxis and supportive therapy in angina pectoris, coronary hypertension and vascular disease.

CONTRAINDICATIONS: Early myocardial infarction.

DOSAGE: One capsule before breakfast, one capsule at bedtime (10 to 12 hour interval).

SUPPLIED: Bottles of 60 capsules.

Samples and literature to physicians on request.

Bradley Laboratories, inc. • 207 Lodi Street/Hackensack, New Jersey

*Trademark


Since the influenza epidemic of 1918
Burroughs Wellcome & Co.
TRADE MARK "TABLOID" BRAND
'Empirin' Compound
COMPRESSED

....the first choice of many physicians to relieve aches, pains, fever, and general malaise of colds and flu.

Symptomatic and supportive treatment of patients with upper respiratory infections still consists largely of rest, analgesics, fluids and nasal decongestants. During the fateful influenza epidemic of 1918, 'Empirin' Compound was widely used and became well known as a well tolerated and reliable analgesic combination. It was one of the few available analgesic products effective in simultaneously reducing fever and relieving the general malaise which often accompany the flu.

Later, 'Empirin' Compound with Codeine took its place with the widely used 'Empirin' Compound, as a product useful when increased analgesia or antitussive action was desired. Today, 'Empirin' Compound with Codeine is one of the most widely prescribed drugs in medicine, providing physicians with a dependable analgesic, especially useful in relieving the symptoms of colds and flu. We believe you will also find 'Empirin' Compound with Codeine Phosphate gr. ¼ (16 mg.) or gr. ½ (32 mg.) particularly useful in treating the troublesome cough that is often part of the influenza symptom complex.

'EMPIRIN' COMPOUND with CODEINE PHOSPHATE *



gr. ⅛ gr. ¼ gr. ½ gr. 1



* Available on oral prescription where State law permits. Subject to Federal Narcotic Regulations.

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NEW ANOREXIENT FOR THE "DIFFICULT PATIENT"

"In the cooperative patient, (OBETROL) *was markedly beneficial in producing the desirable weight loss with minimal side effects, even in the case of a high percentage of patients with cardiovascular and other chronic ailments which normally make use of other amphetamines undesirable because of side effects."* [1,3]

"In a group of 100 patients, of whom 60 had diabetes, arteriosclerosis, hypertension, or a combination thereof, we were able to get weight reduction, using (OBETROL) *and diet...With a daily divided dosage of 30 milligrams of* (OBETROL) *we were able to obtain appetite depression without nervous restlessness or insomnia..." 26 patients who previously had been unable to use other amphetamines in any dosage sufficient to maintain the anorectic effect. responded favorably on this medication* [1,3]

DIABETIC PATIENTS on OBETROL showed improved carbohydrate *tolerance* with decreased need for hypoglycemic agents. [1,3]

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for medical management of obesity[2]

OBETROL is available in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.

Write for samples and literature.

REFER TO PDR

OBETROL PHARMACEUTICALS 382 Schenck Avenue, Brooklyn 7, N. Y.

(1) Simon, F. & Bernstein, A.: "The Treatment of Obesity in Patients with Cardiovascular Disease," Angiology, 32-37, Jan. '61.

(2) Plotz, M.: "Modern Management of Obesity, J.A.M.A., 170:1513-1515 (July 25) 1959.

(3) Bernstein, A. & Simon, F.: "Treatment of Obese Diabetics and Arteriosclerotics," Clin. Med., 907-920, May '61.

* Trademark. A Unique combination of equal parts of Methamphetamine Saccharate, Methamphetamine Hydrochloride, Amphetamine Sulfate and Dextroamphetamine Sulfate. Pat. ‡2748052



who coughed?

HYCOMINE® SYRUP for COUGHS

provides fast and long-lasting cough control

relieves cough in 15-20 minutes • lasts 6 hours or longer • promotes expectoration and decongestion of air passages • rarely constipates • agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE Syrup contains:

Hycodan®	6.5 mg.
Dihydrocodeinone Bitartrate (Warning: May be habit-forming)	5 mg.
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***Special extension of coverage policy providing coverage beyond age 70 with a maximum benefit of $5000 for each disablement with a $750 deductible, available upon request at that age without evidence of insurability.**

SOME HIGHLIGHTS:

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PREGNANCY beginning after insurance in force is covered.

CONGENITAL DEFECTS are covered, if such expenses are incurred either (a) for a child born to a mother who is already insured, or (b) more than three years after the effective date of the Covered Person's insurance.

COSMETIC SURGERY is covered, if the condition to be treated is a result of injury sustained while the Covered Person is insured.

RECURRENT conditions are covered.

NO SPECIFIC LIMIT on number of days in hospital or for professional nursing expense.

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THE EXCLUSIONS:

The plan does not cover expenses which are not reasonable or necessary or caused by or resulting from: the hazards of warfare; injury or sickness contracted while in the armed forces; suicide or attempt thereat; self-inflicted injury; injury or sickness covered by Workmen's Compensation or Occupational Disease Law; supplies or services which are furnished by or at the expense of the Federal Government or an agency thereof; treatment for alcoholism or narcotic addiction; or cosmetic surgery or congenital defects or air travel, except as specified in the policy.

TERMINATION:

As long as the Society's plan remains in force and you remain a member of the Society and pay the required premium, your insurance cannot terminate prior to age 70*. Similarly, dependent insurance continues concurrently with the member's policy as long as the person remains a Dependent as defined if premium is paid.

Full Details of Coverage Are in Policy

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in arthritis: vitamins <u>are</u> therapy

In dealing with the chronic stress of arthritis the physician often faces the problem of nutritional imbalance. High potency B and C supplementation is needed for rapid replenishment of tissue stores of these water-soluble vitamins. STRESSCAPS meet this need and help support the natural metabolic defenses in the disease. Supplied in decorative "reminder" jars of 30 and 100.

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Vitamin C (Ascorbic Acid)	300 mg.
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Vitamin B_{12} Crystalline	4 mcgm.
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Recommended intake: Adults, 1 capsule daily, or as directed by physician, for the treatment of vitamin deficiencies.

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MEMO

TO: All Owners of X-Ray Units in New Jersey

The State of New Jersey has enacted legislation, effective February 1, 1962, which requires that all owners of X-Ray machines have their machines inspected to conform with all requirements of the New Jersey Radiation Protection Code — Special and General Requirements.

The main purpose of this legislation is to protect the operator, patient and any other individuals who come in contact with or close proximity to the machine.

Recent surveys show that a large percentage of radiation-producing machines do not meet all safety requirements and that specific corrective measures should be taken to place these machines in proper operating order.

The Radiological Service Company is prepared to perform inspections and make any necessary recommendations for your X-Ray machine. Our survey is performed with precision measuring instruments. If a machine operates properly and safely, a certificate is issued advising that the machine meets all requirements of the State of New Jersey.

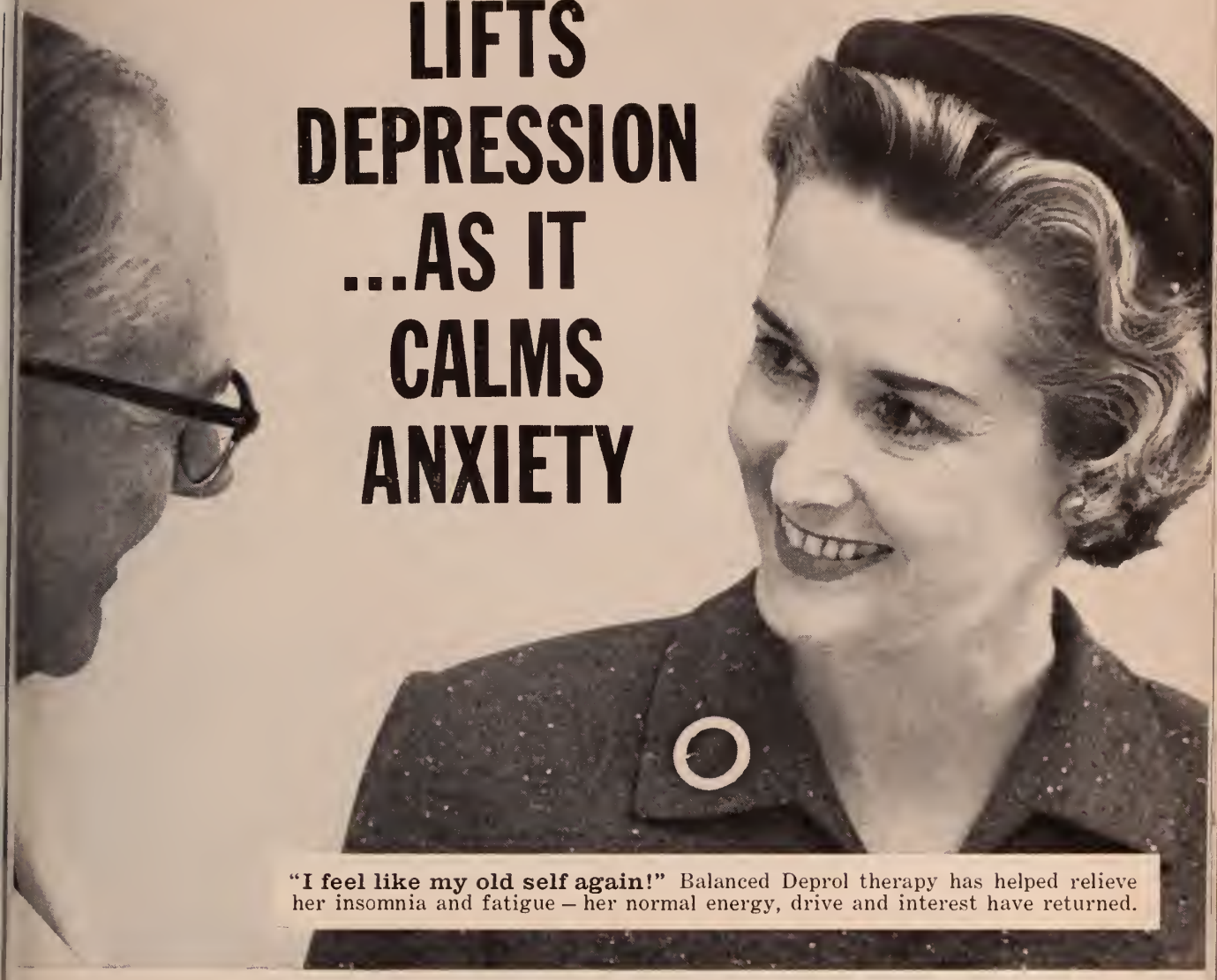
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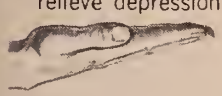
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"I feel like my old self again!" Balanced Deprol therapy has helped relieve her insomnia and fatigue – her normal energy, drive and interest have returned.

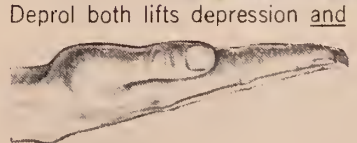
Brightens mood...relaxes tension

Energizers relieve depression





Deprol both lifts depression and calms anxiety





Tranquilizers reduce anxiety

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this may be increased gradually up to 3 tablets q.i.d. With establishment of relief, the dose may be reduced gradually to maintenance levels.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrachloride (benoctyzine HCl) and 400 mg. meprobomate.

Supplied: Bottles of 50 light-pink, scored tablets.

Write for literature and samples.

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CO-7393



Diagnosis: Rheumatoid arthritis

Complication: Pocketbook syndrome

New therapy: HEXADROL®

Dexamethasone 'Organon'

The corticosteroid unexcelled in clinical benefits with cost-to-patient greatly reduced

When you prescribe HEXADROL you give your patients all the clinical advantages of the newer, most effective and best-tolerated corticosteroids. At the same time, you provide relief of the Pocketbook Syndrome, a most common complication of therapy with a steroid of choice. This new and unique benefit of important savings to your patients results from Organon leadership in research, development, and new, more efficient manufacturing processes.

Clinical background? This steroid has a recorded history unequaled in scope and authoritativeness among all the newer corticoids. **Quality?** HEXADROL,® brand of dexamethasone 'Organon'...your assurance of professional quality through research, production and control. **Dosage flexibility?** Tablets 0.75 mg. and new strength 0.5 mg., plus new form, Elixir (0.5 mg. per 5 ml.) now available to meet prescription needs.

Cost-to-patient? Greatly reduced! Why not check with your local pharmacist on prescription cost to your patients?

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Against the formidable and ubiquitous Staphylococcus aureus, PANALBA* gives you a powerful weapon. PANALBA is a selective combination of novobiocin (for its unique effectiveness against staph) and tetracycline (for its breadth of coverage). From the outset, your treatment has broader antibacterial coverage resulting from the simultaneous administration of two antibiotics that complement each other. They were carefully chosen for this purpose.

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New Creamalin®
Antacid Tablets

*"...faster in onset of action...and for a longer period"**

"Clinical studies in 85 patients with duodenal ulcer ...confirmed the superiority of the new preparation [new Creamalin] over standard aluminum hydroxide preparations, in that prompt relief was achieved and maintained throughout the period of observation."*

Patients were followed for about one year.

New Creamalin promotes ulcer healing, permits less frequent feedings because it is so long-acting. Heartburn and epigastric distress were "...easily and adequately controlled...."* New Creamalin has the therapeutic advantage of a liquid antacid with the convenience of a palatable tablet. *It does not cause constipation.*

Each new Creamalin tablet contains 320 mg. of specially processed highly reactive dried aluminum gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles offer a vastly increased surface area.

Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

Now also available—New Creamalin Improved Formula Liquid. Pleasant mint flavor—creamy pink color. Stabilized reactive aluminum and magnesium hydroxide gel (1 teaspoon equals 1 tablet). Bottles of 8 and 16 fl. oz.

Creamalin, trademark reg. U.S. Pat. Off.

*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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ONADOXIN®
r nausea
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firmed in over 7 years
linical success:
adoxin stops morning
ness in 9 out of 10 patients[1]

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tic conditions: postopera-
ly, following irradiation
edures, infant colic.

BONADOXIN®
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time-tested
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1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.

Study involving 287 patients. 261 patients experienced excellent to good results with Bonadoxin for relief of nausea and vomiting of pregnancy. No side effects reported.[1]

2. Albertson, H.A., Trout, Jr., H.H., Daily, F.W.: The American Journal of Surgery (Sept.) 1956.

"As a result of this study, it is our belief that the routine prophylactic use of the combination of meclizine hydrochloride and pyridoxine is a safe and effective method for lessening the incidence of postoperative nausea and vomiting. We are employing this preparation as a routine pre-operative medication."[2]

3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.

Study involving 620 patients, 537 patients experienced moderate to complete improvement of nausea and vomiting of pregnancy with Bonadoxin. Toxicity and intolerance to the medication in the dosage employed in these studies was zero.[3]

4. Codling, J.W.: Lowden, R.J.: Northwest Med. (March) 1958.

Study involving 76 pregnant patients with nausea and vomiting. The results indicated an overall response in 70 of 76 patients treated. No side reactions were observed in this clinical study.[4]

5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.

[Bonadoxin] "was found clinically effective in the prevention of pre-operative and post-operative nausea and emesis in 157 patients who underwent ocular surgery, while control drugs alone could not completely eliminate the symptoms. Bonadoxin did not cause side reactions in the preoperative or postoperative phase of this study."[5]

6. Bethea, R.C.: International Record of Med. (May) 1960.

"Our investigation of this drug indicates that in 88 per cent of the cases satisfactory relief of the distressing symptoms of early pregnancy was obtained without undesirable side effects, including sedation."[6]

7. Sklaroff, D.M.: Karayannis, N.: Current Therapeutic Research (June) 1962.

"Based on these results, indicating 92 per cent effectiveness, meclizine-pyridoxine (Bonadoxin®) may be considered a valuable compound in the control of post-irradiation nausea and vomiting. The preparation proved to be safe and fast-acting in bringing therapeutic relief to carcinoma patients with radiation sickness."[7]



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He gives you more than a "makeshift" layout!

Your G-E x-ray representative works with all kinds of installations. He can judge the type of equipment best suited to the demands of your practice and can help you plan its most efficient arrangement. His detailed layout will take full advantage of dozens of time-and-money-saving details — including suggestions on electric power and wiring requirements, x-ray protective needs, darkroom plumbing and accessories, plus many other recommendations to insure a completely efficient installation.

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(the dual-action anti-asthmatic tablet)

. . . works with nebulizer speed—provides four-hour protection

One NEPHENALIN tablet provides: *air in a hurry*—through sublingual isoproterenol HCl, 10 mg. *air for hours*—through theophylline, 2 gr.; ephedrine, 3/8 gr.; phenobarbital, 1/8 gr.

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Applications for initial coverage and increased benefits considered at all times.*

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*New members have special privileges during first few months of membership; ask for specific details if you were recently elected and have not received notifications from us. All applications subject to company rules and regulations for acceptance of risks.

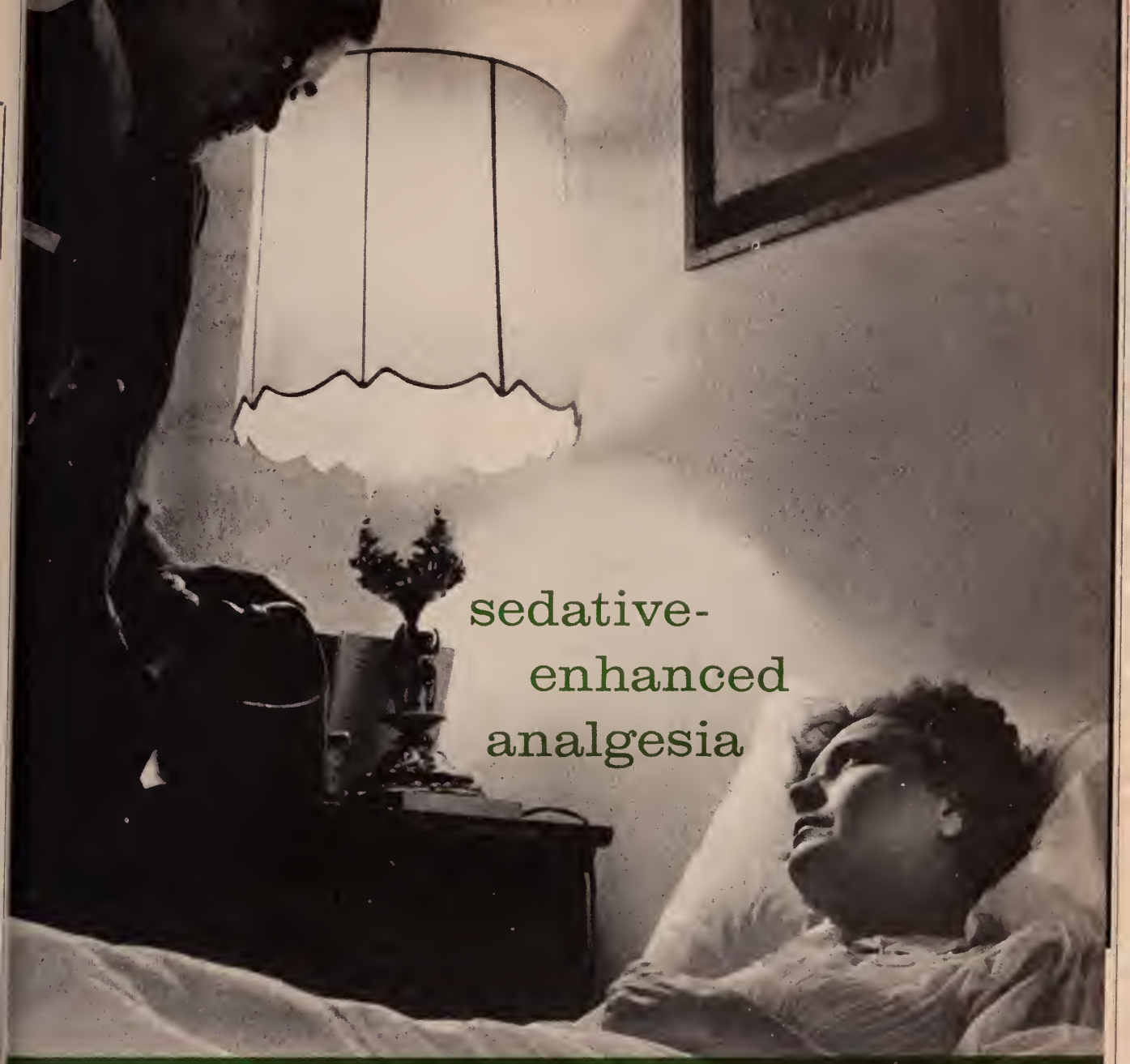
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PHENAPHEN®

- More satisfactory than "the usual analgesic compounds" for relieving pain and anxiety.[1]
- More effective than a standard A.P.C. preparation for relief of moderate to severe pain.[2]

Each PHENAPHEN *capsule contains:*

Acetylsalicylic acid (2½ gr.)	162 mg.
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Phenobarbital (¼ gr.)	16.2 mg.
Hyoscyamine sulfate	0.031 mg.

Also available:

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¼ GR. (16.2 mg.) Phenaphen No. 2

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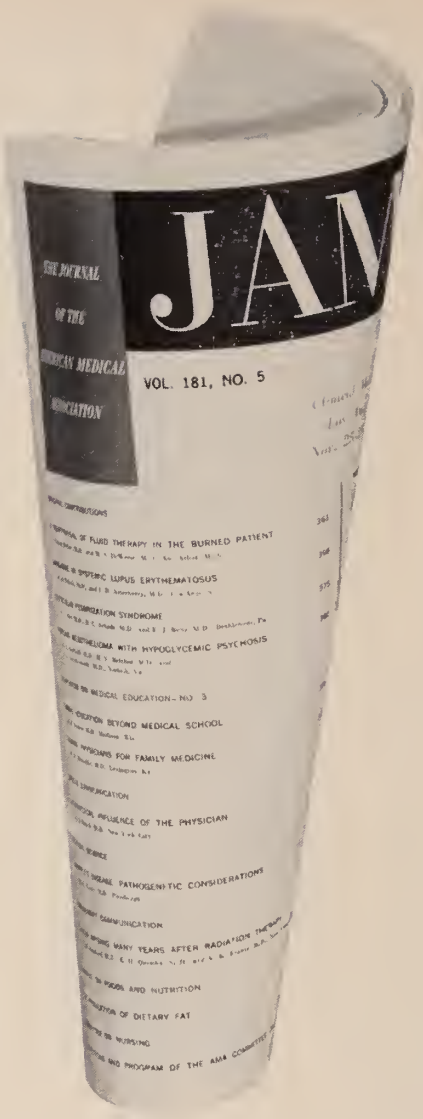
PHENAPHEN with CODEINE PHOSPHATE
1 GR. (64.8 mg.) Phenaphen No. 4

Bottles of 100 and 500 capsules.

1. Meyers, G. B.: Ind. Med. & Surg. 26:3, 1957. 2. Murray, R. J.: N. Y. St. J. Med. 53:1867, 1953.

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Because you are aware of the AMA statement on fat in the diet...

"Increasing the ratio of poly-unsaturated fat to saturated fat in the diet is the preferred method for treating the 'usual' hypercholesteremia."

From the Aug. 4, 1962 issue of The Journal of the American Medical Association.

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When an adjustment in dietary ratio of saturated fat is indicated, Saff-o-life

you should be aware of this new, poly-unsaturated oil for cooking

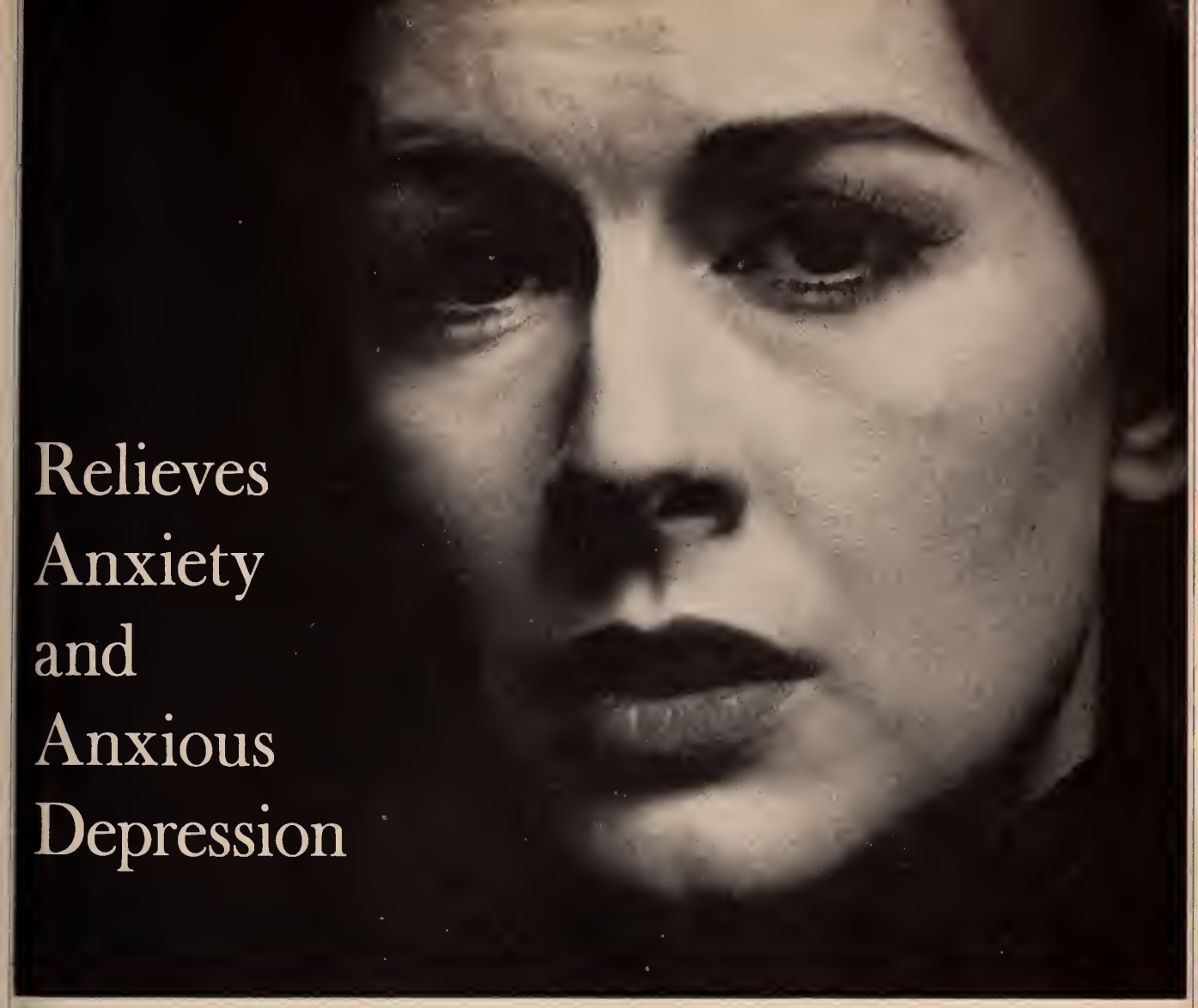
Safflower Oil makes the substitution easy, appetizing, inexpensive.

Physicians who wish recipes using Saff-o-life Safflower Oil are invited to write directly to: Professional Services Director, General Mills, Inc., Department 120, 9200 Wayzata Blvd., Minneapolis 26, Minnesota.

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CORN OIL	5.3 to 1.0
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The outstanding effectiveness and record of safety with which Miltown relieves anxiety and anxious depression—the type of depression in which either tension or nervousness or insomnia is a prominent symptom — has been clinically authenticated time and again during the past seven years. This, undoubtedly, is one reason why physicians still prescribe meprobamate more often than any other tranquilizer in the world.

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meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; bottles of 50. Also as MEPROTABS® — 400 mg. *unmarked,* coated tablets; and in *sustained-release* capsules as MEPROSPAN®-400 and MEPROSPAN®-200 (containing respectively 400 mg. and 200 mg. meprobamate).

Clinically proven in over 750 published studies

1. Acts dependably — without causing ataxia or altering sexual function
2. Does not produce Parkinson-like symptoms or liver damage
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WALLACE LABORATORIES / *Cranbury, N. J.*

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For every kind of pruritus—for adults or children—safe, fast-acting CALMITOL Ointment soothes itching on contact, helps prevent secondary trauma caused by scratching. And low-cost, conservative CALMITOL is non-sensitizing. CALMITOL Ointment is available at all pharmacies in 1½ oz. tubes and 1 lb. jars. For more stubborn pruritus, CALMITOL Liquid in bottles of two fluidounces.
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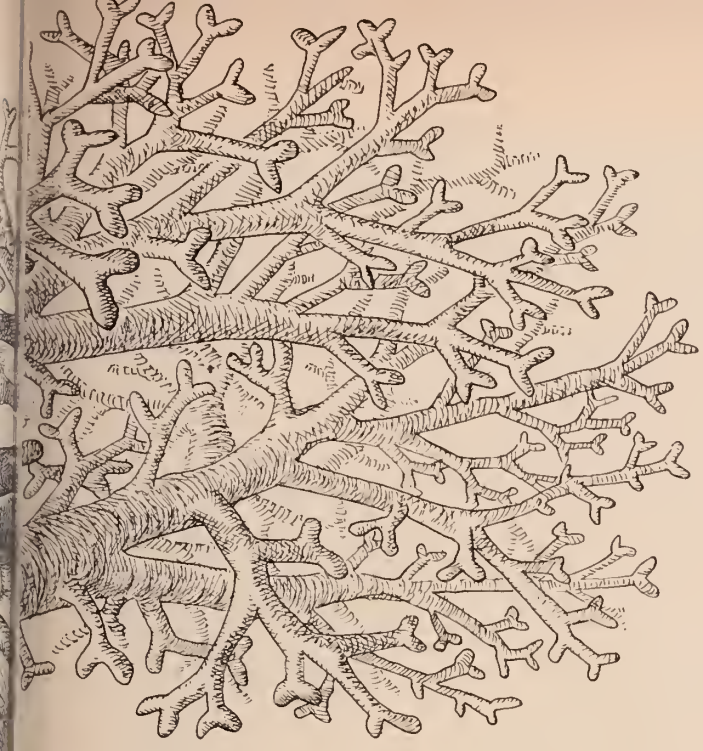
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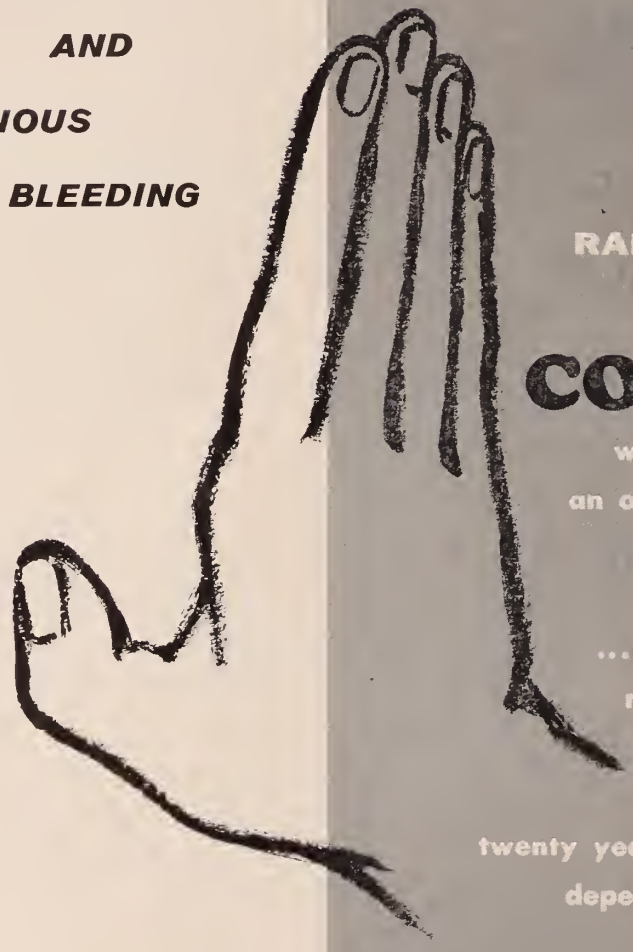
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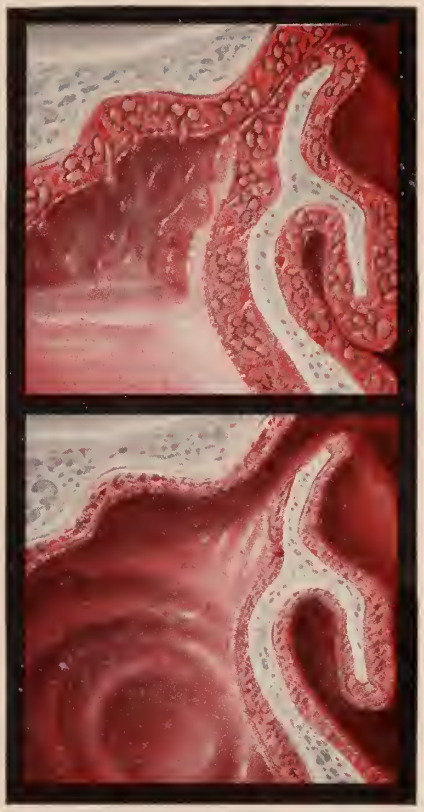
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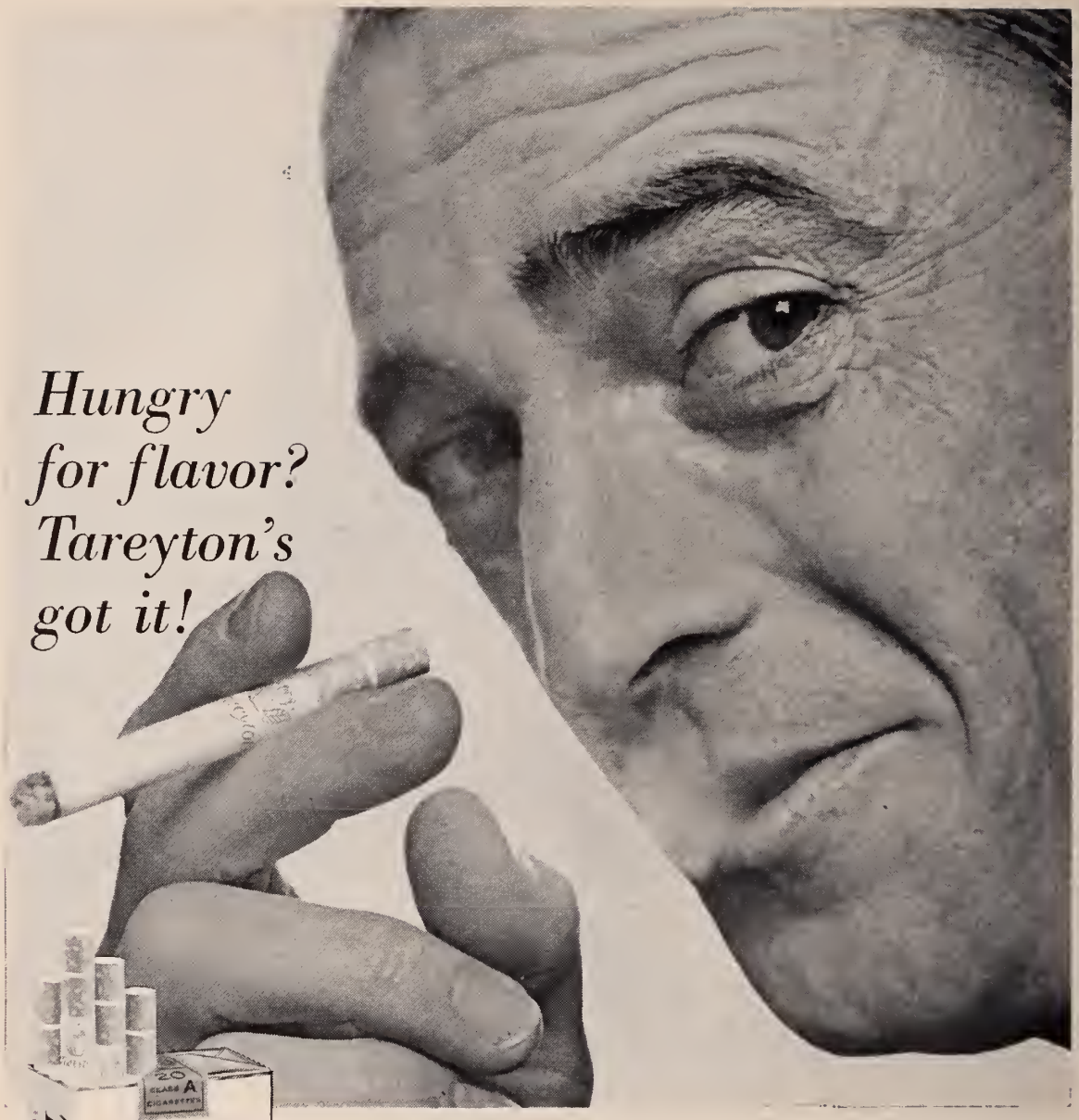
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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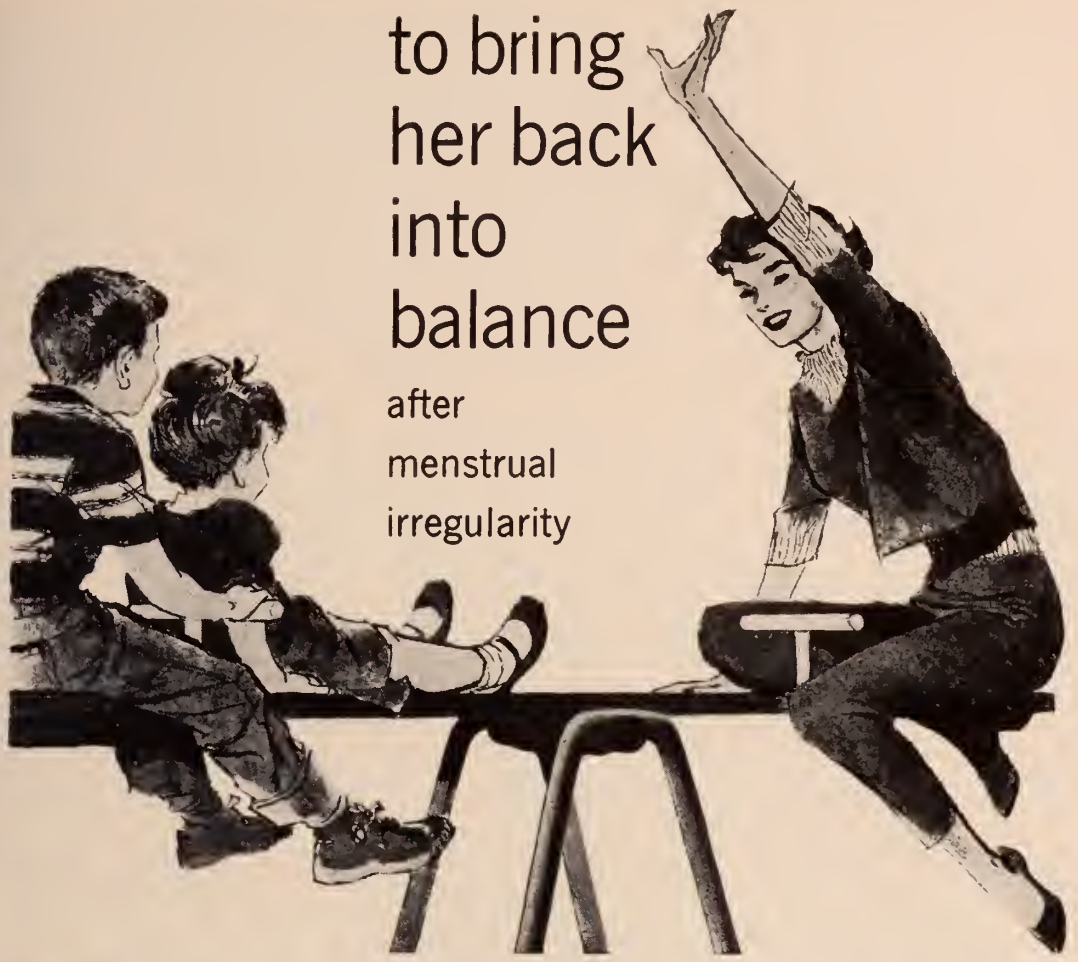
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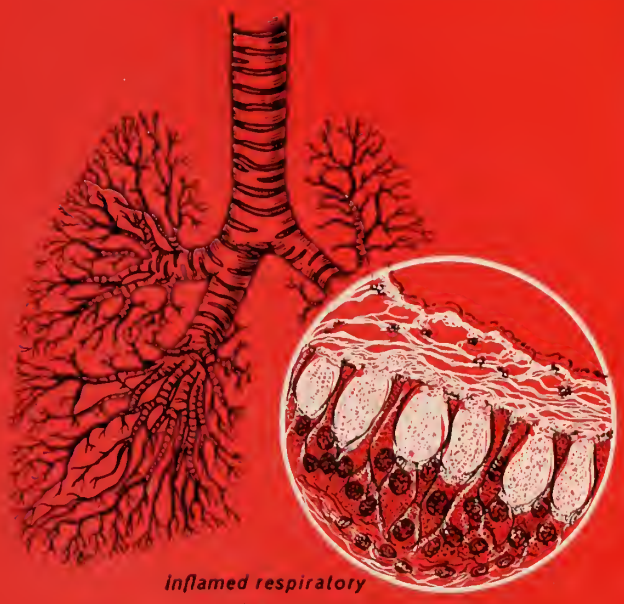


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1. Taub, S. J.: Clin. Med. 7:2575, 1960. 2. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 3. Billow, B. W.; Cabodeville, A. M.; Stern, A.; Palm, A.; Robinson, M., and Paley, S.S.: Clinical Experiences with Oral Anti-inflammatory Enzyme for Intestinal Absorption. Southwestern Med. *41*:286, 1960.

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Issue: Rev. Nov. 1961

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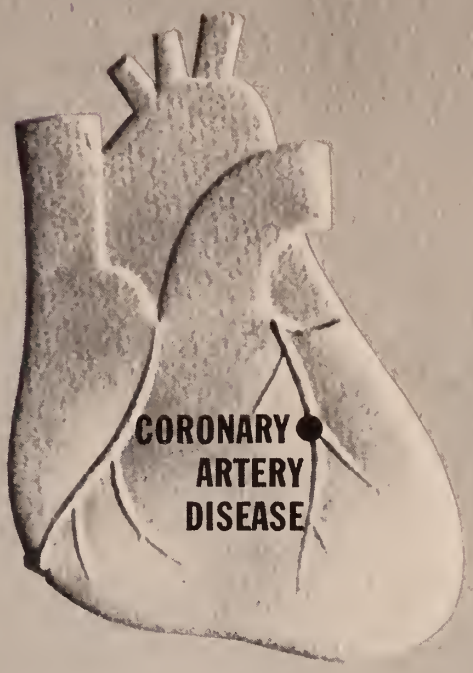
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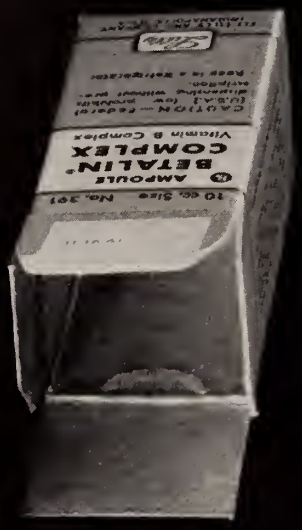
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THE JOURNAL
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Editorials • • •

Back to Materia Medica

The nineteenth century medical student had to learn that opium was derived from the dried juice of the sun-ripened capsule of the oriental poppy, *Papaver Somniferum*. Digitalis, of course, came from the thimble-shaped flowers of the foxglove—*Digitalis purpurea*. The very phrase "materia medica"—the "stuff of medicines" was understood then to mean medical botany. The seal of The Medical Society of New Jersey (see bottom of the front cover of this JOURNAL) carries the phrase *Opiferque per orbem dicor*: I am known throughout the world as the bearer of good things. It refers to Apollo's familiarity with the medicinal qualities of plants.

The development of organic chemistry at the turn of the century changed all that. During the past 50 years, most of the advances in pharmacognosy have been in the direction of pharmacologic synthetics—sometimes the chemist's effort to imitate nature, but more often aimed at a new combination of artificially produced drugs with the hope of developing something stronger and safer. Thus, botanical materia medica seems to be taking a back seat. Certainly no American medical student today is expected to know any botany.

The discovery—or, more accurately, the rediscovery of the pharmacologic value of reserpine suggested that there might be some life in the old plants yet. Today, many pharmaceutical companies have decided to divert some of their research budget into botanical exploration. This is now seen—and properly so—as a forward-looking, not a backward-looking, step. Indeed, last year one company spent almost a half-million dollars* in seeking new drugs from plant sources. "Samples of botanical materials," writes Penick,* "with alleged curative properties are pouring into this country from Central and South America, Africa and Formosa." In this respect, we seem to have gone through three phases since Paracelsus became more fashionable than Galen. First—the stage of credulous belief in the claims of any herb collector; then a phase of botanical nihilism—rejecting all such claims on the theory that any medicinal properties in

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a plant could be better developed synthetically (the digitalis story, for instance); and now, a skeptical, but not a cynical, attitude of suspended judgment towards the claims of curative properties made on behalf of plants by native tribesmen or even witch doctors. The therapeutic potentials of plants have been known (or at least asserted) since the Sumerian tablet of 2100 B.C. described the medicinal effects of assefetida and thyme. But now, for the first time in world history, the resources of modern biochemical, industrial and research technics are being applied to them. For all we know—and we cannot afford to laugh it off—a treatment for cancer or hypertension may still be locked up somewhere in Nature's medicine chest. Perhaps *vis medicatrix naturae* may have a double meaning.

*Penick, S. B.: Journal of the Indiana Medical Association, 55:1040 (July 1962).

Smoking and Our Mouth-Centered World

If a bridge were considered unsafe on the kind of evidence that indicts cigarettes, that bridge would be closed to traffic. Yet people are smoking more and more. Evidence links cigarettes with peripheral vascular disease, pulmonary and bronchial neoplasms and certain cardiac disorders. In the teeth of this evidence, many of us continue to puff away. Fear of smoking saves lives, but we might as well tell it to the marines.

This is one of the oddest of facts. Why? Smoking does not produce a delectable sensation. A cigarette is not a chocolate cake. It does not enslave the smoker the way opiates hook the addict. It does not provide an escape into fantasy as does whiskey. What then are the charms of the cigarette?

The psychiatrist has an explanation but he has trouble selling it. He believes that the mouth is a center of emotions relating to a sense of security. If this sounds fantastic, consider this. A newborn baby has only one source of security; getting food into his mouth. He knows nothing of unemployment insurance or social security. He knows nothing except the need to get something edible into that mouth. Thus at the dawn of life, the mouth becomes the locus of security.

At one time we lived in a world that craved adventure. The college graduate of 1923 was ambitious enough. He hoped to do something glamorous; perhaps to be a foreign correspondent—dangerous but exciting; or an explorer. Or he thought he'd like to establish his own business and sweat it out until it was successful. Or he would go into stocks and bonds and by daring and boldness make a million dollars. The idea of the secure and safe job was repugnant to him.

How about the class of 1963? When a recruiting officer from an engineering firm invades the college campus today, what do the graduates ask? Their first question is not salary, nor chance of advancement, nor the opportunity for professional growth. The Number 1 question is: "What retirement policy does your company have?" So the 22-year old college graduate wants to know how much security he can look forward to when he is 65. And the drive towards security is everywhere in the air. The phrase "cradle to the grave" is commonplace. There is talk of social security, retirement plans, unemployment insurance, Government guaranteed hospital care and so on.

It is easy to see why our younger generation is now so security conscious. Consider that class of 1923 again. Here was the world as he saw it. There would be no more wars, since we had a League of Nations. Prohibition would wipe out alcohol-induced crime, alcohol-precipitated mental illness, and alcohol-caused marital breakdown. Prosperity was everywhere, and poverty was on the run. Medical and surgical miracles were waiting in the wings and disease would soon be under control. The one thing we were all sure of was progress.

The alumnus of 1963 faces a different world.

The one thing he is sure of is a stint in the army. Poverty has not been abolished. More people die of cancer and heart disease than ever before in spite of medical miracles. The mental hospitals are overcrowded and going to a psychiatrist has become fashionable. As for the possibility of war—well, he who runs may read.

So he craves security. And here is where the mouth comes in. It is the organ of security, getting that status from babyhood. He expresses this in many ways. Knowing where your next meal is coming from. An army marches on (and the way to a man's heart is through) his stomach. The mouth as a generator of talk keeps going in high gear. An endless stream of talk pours out of radio and television. Sales of bubble gum burgeon so that this satisfaction-giving organ can be kept busy. When boy meets girl, they chew gum, they kiss, they talk, they smoke, they eat pizzas, they muzzle and nuzzle and, in general, use their mouths as symbols of emotional satisfaction.

Putting something in the mouth thus becomes a symbol of security. It might be chewing gum or even a tooth-pick. Some people suck their thumbs. Some hold empty pipestems between their lips. Some keep sipping coffee several times a day. (In the words of a song in *How to Succeed*: "If I can't take three daily trips where shining shrine benignly drips and taste cardboard between my lips, something within me dies.") Some chew their own fingernails.

And what is America's most widespread disease? Obesity. There is (with a few clinical exceptions) only one cause of obesity. Putting too much into the mouth. But that mouth apparently has to be titillated. Come what may, we're going to get those oral satisfactions if it kills us.

And perhaps it will.

An Old Enemy Still with Us

Elsewere in this issue* we publish an article on the epidemiologic treatment of syphilis contacts. It is disturbing to read that in 1961 there were 872 cases of primary and secondary syphilis in New Jersey compared with only 670 the previous year. Here, we thought, this great scourge had been licked. And now we read that the rate is rising.

No one really knows why this is so. Some think that it is just the irresponsibility of flaming youth. Others feel that we middle-aged people have somehow failed to provide our adolescents and young adults with a hopeful, stable world. We seem instead, to have raised the spectre of atomic destruction, so that a "be merry, for tomorrow we die" attitude is understandable, if not justifiable. As physicians, we can hardly take responsibility for this. Of more direct medical interest is the curious possibility that our very success in treating venereal disease has made it less feared, and therefore more prevalent. At the turn of the century, lads would agree that syphilis was bad—and that it had to be avoided—we almost wrote "like the plague." Gonorrhea, on the other hand, was traditionally, if inaccurately, considered to be no worse than a bad cold. Modern chemotherapy has made syphilis less frightening. The fear of crippling disease was once the beginning of restraint. We physicians have done much to remove the stigma and the danger. And—without meaning to—we have also contributed to the removal of a powerful physical sanction. The development of moral sanctions is, perhaps, beyond our competency, or at least beyond our responsibility.

With the advent of potent antiluetic chemicals, we thought we could relax. The battle against syphilis, we hoped, had been won. But again, we learn that eternal vigilance is needed. An old enemy is creeping back.

*See other side. Also see footnote on the bottom of page 578.

WILLIAM J. DOUGHERTY, M.D., M.P.H.

Trenton

Epidemiologic Treatment of Syphilis Contacts

We used to think that syphilis was under control. It isn't and Dr. Dougherty, Director of our State's Preventable Disease Division, tells what we can do about it.

THE disturbing dimensions of the increase in incidence of infectious syphilis [1] during 1958, 1959 and 1960 in New Jersey and throughout the country have been called to attention. The alarming rise in New Jersey continues as 872 cases* of primary-secondary syphilis were reported in 1961 in comparison to 670 cases in 1960. The current threat of infectious syphilis highlights the need for vigorous epidemiologic treatment of the sex contacts of cases of infectious syphilis.

The resurgence of syphilis in epidemic form depends upon the progressively increasing transmission of the treponeme from symptomatic and symptomless lesions. To stem this tide of infection, it is necessary to destroy the treponeme before it produces a tissue reaction and a lesion which sheds new organisms to infect others. The earlier in the course of infection the treponeme is destroyed, the more effectively is spread reduced and the propagation of new lesions controlled.

RATIONALE OF EPIDEMIOLOGIC TREATMENT

THE rationale of epidemiologic treatment derives from the pathogenesis of syphilis. When the treponeme gains admission to the body and settles in the tissue, there is reproduction at the site of entrance, and, shortly thereafter, dissemination throughout the body by means of lymph and blood streams. The incubation period ranges from 10 days to 10 weeks and averages about three weeks. In most instances, infection is followed by visible tissue reaction at the inoculation site. Generalized tissue reactions usually follow dissemination of the organisms. It is important to remember, however, that either or both of these phenomena may fail to occur or may be so slight as to evade notice.

When the infected secretions of a person with primary-secondary syphilis come in contact with a new host, three possibilities exist: a clinically discernible infection, a symptomless infection, or the organism's failure to gain access to the body. Only the clinically discernible infectious lesions become apparent over the critical range of 10 days to 10 weeks or longer.

The earliest moment when a symptomless infection may be discovered is when the serologic test for syphilis first becomes reactive. Early discovery rarely occurs in this way. Generally, a symptomless infection is discovered later by chance by means of a reactive serology.

During this period of undetected disease, the potential for transmitting infection exists and is unpredictable.

*Provisional count.

1. Dougherty, W. J. and Hammond, D. P.: The Journal of the Medical Society of New Jersey, 57:237 (May 1960).

TABLE 1.

EARLY SYPHILIS INFECTIONS IDENTIFIED AMONG 978 PRIMARY AND SECONDARY SYPHILIS CONTACTS EXAMINED

New Jersey: January 1 - June 30, 1961

Number of Contacts Examined	Number of Early Syphilis Cases Identified			Per Cent of Contacts Infected with		
	Primary or Secondary	Early Latent	Total Early	Primary or Secondary	Early Latent	Total Early
978	315	83	398	32.2	8.5	40.7

RISK OF INFECTIOUS SYPHILIS

TRANSMISSION of syphilis following sexual intercourse and exposure to infectious lesions does not invariably take place; but the sexual contacts of cases of infectious syphilis comprise an exposed population in whom the risk of infection is high. The extent of this risk is clearly observed in Table 1.

The Public Health Service has reported that in 1947 the number of cases of primary-secondary syphilis discovered was approximately the same as the number of early latent cases reported. This ratio indicates that at least one case slipped through earlier case-finding screens for every new infectious case reported. The cases that were missed had been contacts of infectious syphilis.

In New Jersey, in 1957, 1958, and 1959, the early latent to primary-secondary ratios were 4 to 1; 3.8 to 1; and 2 to 1, respectively. In 1960, seven hundred and fifty-five cases of early latent syphilis and 670 of primary-secondary syphilis were reported. The early latent cases contributing to these ratios were at some time in the past contacts of infectious syphilis. They became infected and infectious, progressed to latency, possibly experiencing infectious relapses, and were sources of additional spread of infection.

In the current epidemiologic process, infectious syphilis cases are interviewed and their sexual contacts elicited. The contacts are then located and are referred to clinics or to their physicians. Infected sex contacts are also interviewed to determine their sexual partners. Often the original patient is named back as a partner. In this way very frequently the information provided by the infected patient is verified and the existence of an infectious exposure confirmed. A high degree of reliability can be placed upon histories of sexual exposure and contact information.

Frequently when contacts are first examined, lesions of infectious syphilis are found on the skin, oral and anal orifices and the external and internal genitalia.

On the other hand, many contacts upon initial examination are found free of suspicious lesions. The contact, at this point, cannot be released as free of infection but needs to remain under frequent observations until at least 90 days after exposure. The absence of clinical symptoms and signs and a negative serology after this interval are essential for release.

Four case histories are presented:

Case 1. A woman was named in November 1959 as the marital sex contact of a primary syphilis patient, with recent and continuous exposure. Her husband also named extra-marital contacts. Examination of the wife on November 17 did not reveal any lesions of syphilis. STS was non-reactive. She was not treated but was instructed to return in a month. On December 16, she was again negative on examination and the STS was non-reactive. Finally, on January 29, 1960, she returned to clinic for a third blood test, which was reactive through 64 dilutions. Subsequent physical examination revealed a primary lesion.

Case 2. A girl was named as a contact by a "casual" friend infected with syphilis in the primary stage. The friend was treated September 8, 1959, a few days after exposing the girl to the disease. Serologies on her in September, October and November were non-reactive. No lesions ever were seen on examination. In December, a fourth STS was made, and this time the VDRL was reactive through 16 dilutions. Examination still revealed no

lesions, so the diagnosis of early latent syphilis was made.

Case 3. A woman was named as a marital contact to primary syphilis on September 25, 1959. Exposure during the same week was acknowledged. Blood tests in October, November, and December were all non-reactive, and no lesions were found. She was seen again in January, 1960. At this time she had manifestations of secondary syphilis, including reactive STS, and was brought to treatment.

Case 4. A 20-year old male was named in early July 1960 as a homosexual contact to primary-secondary syphilis, with multiple exposures in June 1960. He was examined on July 13, presented no discernible genito-anal lesions, and had a non-reactive serology. No treatment was given. He was seen in clinic next on August 23 and still did not have symptoms of infection. A blood test on this date, however, was reported reactive. This resulted in further follow-up and a diagnosis on August 30th of secondary syphilis. At this time, secondary lesions were florid. This patient had passed through the primary stage undetected although technically under observation.

The practice of keeping the contact under observation, passively waiting to see if symptoms or serologic evidence of infection appear, is fraught with serious difficulties. Many contacts are irresponsible and fail to follow instructions concerning return for examination. Some move away from their established haunts and are lost to observation. Other contacts refuse to abstain from sexual intercourse. Those failing to cooperate in the observation period are at liberty to incubate infectious syphilis without discovery and promiscuously transmit it to others.

EPIDEMIOLOGIC TREATMENT

EPIDEMIOLOGIC treatment is given for the purpose of destroying all treponemes within the body and arresting the pathogenesis of infectious syphilis in an exposed sex contact who does not have symptoms or signs of syphilis. It consists of the administration of 2.4 million units of benzathine penicillin G to these contacts. In the event of known penicillin sensitivity, an equivalent "broad spectrum" antibiotic may be used, 2 to 4 Grams daily for a total of 20 to 30 Grams within 10 days.

Epidemiologic treatment of the contact at the moment he is brought to examination destroys the treponeme in the incubation period of the disease, eliminates the need for ninety-day observation and reduces substantially the possibilties of spread.

Epidemiologic treatment is not intended as a substitute for thorough examination of contacts and the use of all diagnostic aids, including darkfield microscopic examination of material from suggestive lesions and serologic testing for syphilis.

Most syphilis contacts respect the physician's judgment and respond favorably to the suggestion that by agreeing to accept epidemiologic treatment they acquire protection against the reported exposure. Many are quick to sense a relationship between the treatment and continuation of an active sex life. It is advisable for a doctor to warn a patient that the treatment does not afford a prolonged safeguard against infection.

REACTIONS TO PENICILLIN

A RELATIVELY low incidence of reactions to benzathine penicillin G in an extensive 1959 study is reported in the Public Health Service publication, *VD Fact Sheet* 1960. Reactions occurred at a rate of 12 per thousand patients in this study. No fatalities occurred in the study group.

The possibility of a severe reaction to penicillin must be taken into account, though this is infrequent if caution is exercised. Precautions to be observed are:

1. Question all patients for a history of previous allergic reactions to penicillin or allergy in general. Penicillin should never be given to a patient who has had any form of previous reaction to it and should be given to generally allergic persons only with extreme care.
2. Keep all patients injected with penicillin under observation for 15 to 30 minutes after treatment.
3. An additional precaution taken by some physicians is the simultaneous administration of either antihistamines or corticosteroids with penicillin. This is considered optional at the present time.

Mild urticarial reactions usually can be controlled readily with the antihistamines.

ANAPHYLACTIC reactions may be anticipated by such prodromal symptoms as vertigo, nausea, flushing, itching, or abdominal pain. The presence of any of these should warrant the administration of two or three inhalations from an Adrenalin Medihaler®. If bronchial spasm or laryngeal edema is not immediately relieved, or if the reaction appears particularly significant at its outset, intravenous epinephrine should be administered, slowly, and with frequent checking of blood pressure.

If indicated, an airtube may be inserted in the trachea. There are times when a respirator is most useful. The rate should be kept at from 10 to 20 per minute. Where the emergency warrants, an emergency tracheotomy should be done.

In addition to epinephrine and the foregoing measures, the following medications have been found helpful:

500 mgm. aminophyllin intravenously.
50 mgm. diphenhydramine hydrochloride intravenously. (Trade named Benadryl®)
800,000 units Neutrapen® (penicillinase) intravenously.

If a patient goes into shock, 500 milliliters of 10 per cent glucose in normal saline may be given intravenously, and 20 milligrams (in a one milliliter ampule) of a vasopressor such as l-norepinephrine may be introduced intravenously at a rate sufficient to maintain adequate blood pressure levels. Another drug sometimes useful in severe shock is hydrocortisone succinate (Solucortef®) 100 milligrams slowly administered intravenously, either by itself or mixed with glucose in normal saline.

COMMENT

A MERE holding action against syphilis, using only the defensive technic of dutifully treating every diagnosed case, no longer will suffice. There is no justification for ignoring the threat of epidemic syphilis and its concomitant perils. The call for an aggressive, *preventive* program to combat syphilis is clear. Further losses to syphilis due to our failure to recognize the disease and reduce its spread are inexcusable; every loss is irretrievable.

The concept of prophylactic or epidemiologic therapy is currently accepted by the medical profession in the United States. In the presence of exposure to meningococcus infection, sulphadiazine for non-infected contacts is advised. Penicillin is given to children and adults with a history of rheumatic heart disease for the prevention of streptococcal illness. Isoniazid is given prophylactically to young children exposed to active tuberculosis. Penicillin is used to treat epidemiologically the female contacts of male gonorrhea patients.

The New Jersey State Department of Health has advocated epidemiologic treatment of syphilis for a number of years, and in the present exigency strongly recommends its acceptance by all physicians.

SUMMARY

1. Forty per cent of the 978 primary-secondary syphilis contacts examined in New Jersey from January 1 to June 30, 1961 were infected with early syphilis.

2. The administration of epidemiologic treatment to sex contacts of infectious syphilis cases is urgently recommended.

The State Department of Health

Note: Also see Abstract on the bottom of page 578.

Francis I. Tomlins, M.D.

Ridgewood

Athletic Injury Prevention Equipment*

Report of a Research Questionnaire

The prevention of athletic injuries is a much neglected aspect of medical practice. This practical report highlights some of the problems.

A QUESTIONNAIRE was developed to obtain a cross-section of responsible opinion on the subject of equipment used in preventing football injuries. The information will be relayed to our high school athletic departments in Bergen County to aid in improving their athletic injury prevention programs. In sending out this questionnaire, I first stated my opinion and then presented questions related to football face guards, football helmets, and ankle wraps. Each section ends with my conclusions.

FACE GUARD

THE face guard should be attached to the helmet so that the distance from the bottom-front edge of the helmet to the top of the guard in front of the nose, should measure approximately 2¾ inches. Apparently, the manufacturers do not recommend any set distance. No specific instructions are incorporated in the rule book. The face guards are attached to the helmets by managers, coaches, and others pretty much "hit or miss." At least on the high school level I have found this to be true.

Question—What standards do you employ in attaching the face guards?

In my opinion the face guards protrude far more than is necessary to protect the face. The guard should be brought in so that the player has just enough room to comfortably put on and take off his helmet.

Question—What is your thought concerning this matter?

Jules H. Reichel of Syracuse says: "Our face guards are put on by one of our machinists. The boy puts on the helmet and then holds the guard where it gives him adequate protection for his nose and teeth. We mark the places that are to be drilled and the guard is fastened to the helmet. Since some noses are longer and faces shaped differently, a guard must be properly fitted. We use some of the type that can be adjusted; but they are made of plastic and sometimes will snap in cold weather. I agree with you, doctor, in having the face guard brought in closer to the face as I can see no reason why they should protrude out so far." (Rigid type used.)

Allan J. Ryan, M.D., Committee on the Medical Aspects of Sports, writes: "I believe that the face guard should be redesigned with a clear plastic material so that the space between the top of the guard and the helmet is narrowed and that it is made more difficult for someone to grab the guard, twisting the head. This would probably involve bringing it in closer to the face."

Charles H. Yocum, Manager, Elastic Products Division, Becton Dickinson & Co. says that my concept about the attachment of the face guard to the helmet is basically correct. "In my opinion,

*Dr. Tomlins is a member of our Bergen County Medical Society's Committee on Athletic Injuries.

it is a matter of individual contours; we try to fit the face guard to each individual. We have permitted only the coaches and the writer to fit this. We do not let the team managers have anything to do with it. The type of face guard determines a great deal how it should be fitted to the helmet. With reference to your question as to whether face guards made today protrude too far, I think you are correct. I have never seen as many different types of face guards as I have this past year. Some of them have more bars and protuberances than a catcher's mask in baseball."

R. L. Chambers of Duke University writes that they use a pliable nylon face mask that is adjustable to protect the area we are interested in protecting. "The face guard protrudes just enough to keep it from coming in contact with the face on a hard blow."

H. R. McPhee, M.D., Princeton, answers: "The face guard we have been using for the past two years is the adjustable rachet type. We have them attached at the factory in holes already in the plastic helmet. The guard projects farther than need be. I believe that modern guards do not protect as they should. Actually, they funnel blows into the face. I would like to see them taboo. If it is necessary to have something to protect against facial damage, I favor the mask."

Augustus Thorndike, M.D., Harvard, writes: "The fact that so many face guards have to be worn distresses all of us. Why cannot the Rules Committee legislate against elbow blocking? We fit the guard so close to the face that it barely allows room for putting on and taking off the helmet."

Col. P. W. Mallory, M.C., Hospital of the U. S. Military Academy explains that "face guards are attached with wooden forms that place the mask in proper position 90 per cent of the time. The other 10 per cent the helmet is placed on the player and the mask adjusted to his face. Face masks should protrude just far enough to protect the face and not form a lever. Managers do not attach masks. Some favor doing away with face guards and making it mandatory to wear mouthpieces. Bird cages (rubber-covered full face masks) should be attached only in case of injury."

Ernie Biggs of Ohio State University reports that: "Manufacturers have templets which they send with face guards which would make all guards standard in their attachment. The standards which we employ are individual for the length of the boy's face. We want a double bar with the top bar covering the tip of the nose and the bottom bar striking about the level of the mandible. Face bars generally protrude too far from the helmet. Rawlings is now making a three-bar face guard, attempting to bring the bars closer to the face. I am interested in seeing this face guard."

CONCLUSIONS ABOUT FACE GUARDS

From this survey, the following conclusions seem valid. Face guards should (1) be individually fitted to each player's helmet, with the distance from the bottom-front of the helmet to the top of the guard in front of the nose being approximately 2¾ inches. Any variance would be in keeping with the individual's facial anatomy.

2. On the high school level, fitted individually only by the head coach, assistant coach, or an adult properly trained as a trainer.

3. It seems to be the general opinion that they protrude too far. This should be corrected by the manufacturers, who should use materials that will not snap in cold weather, yet not be too rigid to absorb some of the force of impact. The double-bar face guard appears to afford the best protection.

4. If face guards must be worn, strong penalties should be placed in the rule book to apply whenever a face guard is intentionally grabbed by a player.

5. The possibility of time penalties similar to those used in ice hockey might be considered. If, in the opinion of the official, *intent* existed when the face guard was grabbed, then the offending player should be put out of the game for 5, 10, or 15 minutes. If he offends again, he should be banished from the game.

6. If such a time penalty procedure should be adopted, I suggest that (on the high school level) the officials should come from an adjacent county. No official should work a game in his own county. On a university level, officials should come from an entirely different conference. After all, this would be a "judgment" penalty and it would be unfair to place officials in such a position as to bring about uncalled-for "tongue wagging," especially if the star player was banished from the game.

HELMET

When two plastic helmets collide, they quickly skid off each other and the direct point of contact is quickly dissipated. Suppose

a plastic helmet is covered on the outside with a soft covering to minimize the battering-ram effect? Then will the colliding helmets "stick" to each other and lengthen the time of direct point of contact and possibly produce a greater force upon each player's head?

If an uncovered plastic helmet strikes a covered plastic helmet, will not the plastic helmet *not* covered stick instead of skidding off and produce this same effect?

Question—What has been your experience and what is your opinion?

Is the plastic helmet dangerous? Or is it the way the helmet is utilized in actual play that makes it dangerous? Is it good football when the helmet is used to block by striking the opponent head-on and riding the helmet up over the chest into the face guard? In my opinion both players are in danger of serious injury.

Question—What is your opinion as to the dangers, if any?

Jules H. Reichel, Syracuse, answers: "We have never played a team that have had their helmets covered with a soft material on the outside. What the effect would be when such a helmet comes in contact with a plastic helmet I do not know. The plastic helmet is good protection when worn and used properly. When it is used as an offensive weapon, it is then dangerous and lethal. Some teams use the helmet as a battering-ram into the chest. Some day I hope they make a ruling requiring all helmets to be made with a soft outer surface, such as leather or composition, that has a yielding surface."

Allan J. Ryan, M.D. Dr. Ryan is chairman of the Committee on the Medical Aspects of Sports. He does *not* believe that utilizing a strip of cushioning material on the outside of the helmet would increase the danger of prolonging contact and increasing the amount of injury. "If the force is sufficiently great, the contact only needs to be momentary to produce severe injury. I agree that it is the *manner* in which the helmet is used in play that tends to provoke some of the serious head injuries. On the other hand, some blows sustained in falling are unavoidable. They are due neither to misuse of the helmet nor to the alleged overconfidence of the player because he is wearing the helmet."

Charles H. Yokum (Becton, Dickinson) writes: "I cannot believe that two plastic helmets unpadded on the outside skid off each other as much as it might seem. A great deal has to do with the method which has been taught to the player relative to ducking his head just before contact. This does more to effect a battering-ram result than does the mere fact that the helmets are smooth plastic. The best helmet on the market is one which is padded both inside and outside, and has padding over the back edge of the helmet where it comes in contact with the back of the neck. Regardless of the effect on blocking, this is the safest helmet for the wearer, and his opponent as well."

O. W. Dayton of Yale has had no experience with covered helmets but writes: "I feel sure that in many instances the athlete will use the helmet as a weapon."

R. L. Chambers of Duke University replies: "We have never played a team with covered helmets so we have encountered no difficulties. We have no problems in practice with root canal or brachial plexus stretches because of the helmet sticking and turning the head. In regard to blocking with the head, this is the coach's department and the coach will teach men the more effective way of blocking. We use a football helmet with side suspension. It is padded at the top to help decelerate the head-on blow. The helmet is covered with a half-inch strip of Ensolite® on the outside."

H. R. McPhee, M.D., of Princeton writes that they have used the unpadded plastic helmet since 1946. "The question you raise about sticking has never occurred to me. You may have a good point. We have used the plastic helmet daily since 1946. If the helmet causes more injuries to others than the wearer, we should have experienced a rise in incidence after we adopted them. We did not, and we have experienced a decrease in bad concussions. Our coaches do not teach our men to use the helmet as a weapon."

Augustus Thorndike, M.D., at Harvard refers to the work of the late Dr. Edward Dye at the Cornell Aeronautical Laboratory in Buffalo as the only published scientific study of substantial importance. "Dye calculated the force of impact between an opponent's knee and a tackling player's headguard. The number of foot pounds was astounding. Any method of suspension of a helmet and any insulation that will disperse this force of impact and reduce its effect on the skull and its contents is the most important factor in prevention of injury. The MacGreggor E-700 comes the closest to providing this. I don't believe the uncovered plastic helmet provides any cushioning or dispersion of the impact on a head-on tackle and, sad to state, some coaches are teaching this method of tackling."

Col. P. W. Mallory, M.C., of West Point says that plastic helmets do skid off each other and that the blow is dissipated. "More emphasis should be placed on fitting suspension helmets. A helmet

should be assigned to each man. No one else should wear this helmet after it has been properly fitted. A helmet should fit so tightly that it is almost uncomfortable. Also, different size jaw pads should be utilized to keep the helmet from rocking. A helmet that is too large causes much damage, because when the mask is hit, it causes the back edge of helmet to cut or crush the back of the neck. Players do use helmets as "battering-rams." When a high school player is substituted, he may throw his helmet to his replacement. This practice should not be permitted, particularly if the helmet will not fit properly."

Ernie Biggs of Ohio State writes: "We have worn the plastic helmet covered with insulite for two years and our incidence of head injury has been lowered 40 per cent. Loss of time from practice has been lowered 80 per cent. This is a significant statistic. The length of time to impact exposure would dissipate the force somewhat and even if exposure may be longer, the force will be less. One type of helmet is producing more problems than others, and this is due to the rigidity of the shell, the firmness of the suspension and the shape of the shell across the nape of the neck. The head wasn't meant to be a battering-ram but as long as we have this execution of blocking technic, we can expect to have problems. Our answer to this has been a strong emphasis on head and neck exercise, plus the change of helmets. Using the head in this manner of blocking makes a face guard mandatory. Neurosurgeons tell us there is a strong relationship between the incidence of head injury and the strength of the muscles of the neck."

CONCLUSIONS AS TO HELMETS

1. There is general agreement that the most important aspect of protective headgear equipment is proper individual fitting by a trained individual. The helmet should fit so tight that it is uncomfortable and at least as tight as a "new hat."

2. The hard-shelled plastic helmet appears to afford the best protection.

3. The importance of the chin-strap is often overlooked. How often is a chin-strap actually fitted to the individual athlete? He is given a chin-strap, puts it on, and quickly tightens it. Is it ever inspected to see if his chin actually fits the strap? I don't think this is done.

4. No player should ever be allowed to wear any helmet other than the one individually fitted to his requirements.

5. Part of the pre-scrimmage and game warm-up should include inspection of the helmet's suspension, jaw pads, chin-strap, and fit by the head coach or his assistant on the high school level, and trained personnel on the university level.

6. The helmet, once put on, should under no circumstances be taken off by the player until after the scrimmage or game is over and the players have left the field. The only exception naturally would be in the case of an injury; then it should be removed only at the order of the team physician, trainer, or coach.

7. I do not believe anyone is basically concerned with the care rendered by universities and high schools who have well-trained and dedicated personnel. What is disturbing is the possibility of our being too hasty in adding something new to our helmets or initiating a change that on paper seems to be an improvement, but when placed in the hands of many of our colleges, preparatory schools or high schools may produce more head or neck injuries in institutions where the helmet might be poorly fitted or made of inferior materials.

8. Today the trend to cover the back of the helmet with protective padding to minimize the neck injuries is certainly an improvement.

9. The technic of using the plastic helmet in blocking or tackling, such as "spearing" or as a "battering-ram," is generally strongly condemned.

10. There is no substitute for proper pregame conditioning of the entire body, especially the neck, in preventing head and neck injuries.

11. In spite of our improved helmets today, plus the added improvements in the near future, one fact stands out: a poorly fitted headgear is a worthless protective piece of equipment in any sport requiring head injury protection.

ANKLE WRAPS

IT is my opinion that an ankle wrap should not have any special length but be long enough to anchor the heel and ankle of each

youth according to the size of his foot and ankle. The question asked was: Do all of your players receive the same length wrap or do you individualize?

Jules H. Reichel, Syracuse: "Our ankle wraps are all cut the same length: 72 inches. The reason is that the wraps from time to time (especially after having been laundered) become frayed at the ends. We trim off the frayed ends. That still leaves enough wrap to give adequate support."

Allan J. Ryan, M.D.: "The wrap should centainly be long enough to fit the needs of the boy with a very large ankle. It should be available in several sizes so that the boy with the small ankle does not have too much bulk in his shoe."

Charles H. Yokum: "The wrap does not have to be of any special length, so long as it is long enough to fit the individual. We have found that the regular Ace® bandage cut in half furnishes ankle wraps for one player for both feet. If the ankle wrap is put on in figure eight style with heel lock turns, any excess can be wrapped in layer fashion above the malleoli. Then three to four strips of 1½-inch adhesive tape can be put on in stirrup fashion. This will give good support and provide the mobility for running. All of our players receive the same length of wrap; but they are applied to meet the needs of the individual on whom they are placed."

O. W. Dayton of Yale: "We do not individualize; we use a wrap 108 inches long. This will fit all ankles. We also include the heel lock in all of our wraps."

R. L. Chambers of Duke University: "We use a 90-inch herringbone ankle wrap to protect the ankles of our players in practice."

H. R. McPhee, M.D., of Princeton: "We use the 72-inch ankle wrap, which we find adequate for the largest ankle; and the extra turn or turn and a half about the leg portion of the ankle does no harm to the smallest ankle."

Augustus Thorndike, M.D., of Harvard: "We use a standard 70-inch webbing for everybody."

Col. P. W. Mallory, M.C., West Point: "All our ankle wraps are 101 inches long and we have found no trouble as to fit."

Ernie Biggs, Ohio State: "We use one length only. When you are preparing a squad for practice, it is time-consuming to have to check the length of a wrap before applying it. Wraps are applied over the socks. If one boy's ankles are smaller, we make an extra figure of eight turn with the wrap. I wouldn't consider the variance in size to be much of a problem in the length of the wrap. The conformity and tension of application are much more important."

CONCLUSIONS ABOUT ANKLE WRAPS

1. It is surprising to realize that there exists such a difference of opinion as to the length of an ankle wrap.
2. It is my opinion that if you incorporate the heel lock, the ankle wrap must be at least 90 inches in length and fitted to the size of the athlete's foot and ankle.
3. If the heel lock is not employed, a shorter ankle wrap may be used; but it is recommended that the "heel lock" then be applied by the use of adhesive tape.
4. I suggest that the "buddy system" be employed so that each athlete will be assured of having his ankle wraps properly applied at all times.

SUMMARY

THE results of the questionnaire on three items of athletic injury preventive equipment have been reviewed and conclusions drawn.

In any high school athletic injury prevention discussion the following four points stand out as most important and are here submitted for general consideration.

1. More active role of the team physician in matters of physical fitness, and prevention and care of athletic injuries on the high school level.
2. Development of high school trainer programs.
3. More effective preventive taping and bandaging, plus increased training facilities for coaches, trainers, and physicians on the high school level.
4. High standards by all personnel who officiate the games.

I thank sincerely each individual who contributed his opinions in connection with this questionnaire.

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Urologic Complications of Pregnancy*

Here is a veritable monograph on those rare but sometimes disastrous urologic complications of pregnancy.

Urologic complications during pregnancy are relatively few considering the severe stress imposed upon the urinary tract by gestation. The stresses and dangers are the result of trauma during vaginal delivery, increased incidence of bacterial invasion of the functionally and mechanically dilated urinary tract, severe reversible impairments of renal function, severe reversible hypertension, and acute renal failure due to causes specific to gestation and surgical shock. If, in addition to these, one considers the problem of urinary calculus during pregnancy, pre-existing renal lesions such as hydronephresis, renal ectopia, postpartum atony of the bladder and the always present danger of neoplastic disease, the wonder is that the urologist and obstetrician are so infrequently brought together by serious problems. The answer must lie in the great advance in obstetrical practice, control of infection by antibiotics, improvement in treatment of renal failure and general increase of surgical and urologic knowledge.

Impairments of renal function during gestation fall into two groups: (a) those subject to correction by termination of the pregnancy through properly selected procedure and (b) those called "acute renal failure," caused by catastrophic reduction of renal perfusion. The first (the specific "toxemia of pregnancy") is an obstetric problem. Acute renal failure with anuria, oliguria and surgical shock follows some obstetric procedures or spontaneous delivery.

The basic factor in acute renal failure, or acute tubular necrosis or lower nephron nephrosis, is reduced renal perfusion. If renal ischemia is sufficient, deterioration of renal function follows. The commonest causes of reduced renal perfusion are shock from bleeding and sepsis. During pregnancy this catastrophic failure may follow massive bleeding of abruptio placenta and ruptured uterus. Postpartum atony and sepsis with sustained hypotension are also causes. Incompatible emergency transfusions during massive hemorrhage may also cause acute renal insufficiency. The diffuse renal cortical necrosis which may follow reduced renal perfusion during pre-eclampsia and eclampsia is probably the most malignant form, being protracted and less reversible. However, renal cortical necrosis can occur irrespective of the toxemic state if renal ischemia is very severe.

Better than any therapy is the prevention of the acute renal failure syndrome by meticulous, well-matched replacement of blood loss, by the detection and early treatment of shock, and by control of infection. Therapy by intravenous infusion of mannitol at the earliest onset of oliguria gives promise of reversal of

*Read May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

functional failure, with prevention of total organic renal failure. Organic failure, however, is the usual form of acute renal failure during pregnancy.

The syndrome has two phases. A period of oliguria or anuria which (if not fatal) is followed by a period of diuresis. If reversible, recovery of renal function and survival result.

OLIGURIC PHASE

DURING the oliguric phase scanty quantities of urine are produced, 400 cubic centimeters or less a day. Urinalysis reveals fixed specific gravity ranging about 1.010, acid reaction, red and white cells, casts and much debris. Aside from anuria or oliguria, there may be no clinical evidence of renal failure. Progressive rise of blood urea nitrogen of 15 to 30 milligrams per day, serum creatinine rise of 1.5 per day, reduction of plasma sodium and chloride concentration, decrease of buffer base bicarbonate and increase of acidosis, increase of potassium serum levels, may become threatening by the seventh day. If fluid and salt intake are excessive, congestive heart failure may ensue by the end of the first week of the oliguric phase.

When urinary output exceeds 800 cubic centimeters per day, the diuretic phase has begun. During this phase the patient may become more gravely ill with hyperkalemia and congestive heart failure or death may ensue due to uremia. Only after daily urinary flow has reached 1000 to 1500 cubic centimeters for three or four days do the evidences of uremia subside.

The improvement in the treatment of acute renal failure has been in the conservative management of the oliguric phase. More now survive to enter the diuretic phase. Fluid administration must be acutely reduced so that total intake does not exceed total output by more than 500 cubic centimeters. Expansion of extra cellular volume followed by increase in plasma volume and venous return may cause congestive heart failure. The lethal effect of hyperkalemia with characteristic electrocardiographic changes and exaggeration of catabolic factors are well known. Prompt control of independent infection or tissue necrosis as well as adequate caloric intake of fat and carbohydrate are essential. Small infusions of 25 to 50 per cent sugar solutions, testosterone, regular insulin and potassium-free cation exchange resins have been tried.

DIURETIC PHASE

The symptoms which cannot be attributed to congestive heart failure, hyperkalemia, hypoelectrolytemia or anemia after eight days of acute renal failure are uremic due to accumulation of nonexcreted toxins. Dialysis, peritoneal, gastric and extra corporeal add another therapeutic method for the elimination of toxic products and may keep the patient alive several more days during which continued tubular regeneration may increase the chances for ultimate survival. This is especially important in severe renal cortical necrosis where survival was rare before dialyzing technics were available. Failure of all other methods of controlling hyperkalemia with danger of sudden cardiac standstill is an indication for dialysis. Increasing signs of drowsiness, apathy, twitching, convulsions, bleeding tendencies, gastritis, colitis or other uremic signs are an indication for dialysis. Dialysis should be considered before a point of desperation is reached.

Physiologically, the diuretic phase leads to return of tubular function during which large quantities of salt, water, and potassium are excreted. The basic principle of therapy at this phase is replacement of losses of solute and water so that the maintenance of total fluid intake at daily output plus 500 cubic centimeters is imperative. Salt infusions are given in the form of two parts chloride and one part lactate. Addition of potassium to the infusate may be necessary. Reduced kidney function may persist for months or years.

PYELITIS

THE era of sulfa therapy and versatile antibiotics has given some measure of con-

trol and cure for pyelitis of pregnancy. Bacteriuria in the presence of the ureterectasis and pyelectasis of pregnancy occur in 46 per cent of cases studied. Among these cases of positive culture, about 30 per cent have acute pyelonephritis. Sulfonamide therapy controls about 90 per cent of the infections, and specific antibiotics and nitro-furantoin are usually effective for the remaining 10 per cent. Failure of response to these should indicate urographic study for calculi or other renal disease.

INJURY

TRAUMA of the urinary tract has been reduced by the vast improvement of obstetric practice. Injury of the bladder during labor and cesarean section is avoided by the judicious use of the catheter. Vesico-vaginal injury during delivery has been largely eliminated and vesico-vaginal fistula is rare. The almost total disappearance of "high" and "high mid" forceps and the increased use of cesarean section have largely eliminated this unhappy result. However, injuries of the bladder do occur during cesareans and ureteral injuries have occurred in puerperal hysterectomies. Troublesome hemorrhage is usually the cause.

RETENTION

URINARY retention postpartum has been encountered only once by us. This occurred in a patient where intermittent and indwelling catheterization had been necessary for four weeks following delivery. A brief report of this case is included. Routine catheterization and cystoscopy have been advocated where retention or bloody urine follows a difficult delivery. Early ambulation, parasympathominetic drugs, and the indwelling catheter have been effective. All postpartum patients will void after a few days. Since urinary retention in females has been encountered by us not too rarely in nonpregnant women where endoscopic resection was necessary for cure, we see no reason why urinary retention should not be encountered in the postpartum period when the trauma of labor may add to latent factors which cause retention in the female.

CASE ONE

A 35-year old gravida 3, para 3, delivered her third child two weeks previously and was admitted to the Perth Amboy General Hospital on October 2 with inability to void since delivery. She required constant foley catheter drainage. On several occasions when the catheter had been removed, the bladder became greatly distended with urine. On one occasion prior to hospital admission, 2700 cubic centimeters of amber urine was obtained during catheterization. She had no other complaints, except inability to void, following her delivery. She was treated conservatively by intermittent catheter drainage along with Urocholine® medication, but at no time during this period did she succeed in voiding spontaneously. On October 20, cystoscopy was done under spinal anesthesia. The floor of the bladder neck was markedly elevated and presented the appearance of a middle lobe prostatic hypertrophy as seen in the male. No associated bladder pathology was noted. Using a 28 McCarthy resectoscope, six slivers of tissue were resected from the bladder neck on the floor and lateral aspects. Bleeding was controlled by electrocoagulation and a 24 foley catheter with a 30 cubic centimeter inflated bag was left indwelling in the bladder. Pathologic diagnosis was chronic cystitis and bladder neck compatible with fibrous contracture. Three days postoperatively the catheter was removed from the patient's bladder, and thereafter she voided voluntarily. She was discharged from the hospital on October 28, in satisfactory condition. She has had no urinary complaints since her transurethral bladder neck surgery.

Acute retention persisting for weeks after delivery was cured by resection of obstructive elevation of the vesical neck which had been due to vesical neck contracture.

CALCULUS

CALCULUS disease in pregnancy is a disturbing occurrence. Stone formers become pregnant and all the complications of calculus disease of the kidney and ureter may occur during pregnancies. The incidence of calculi during pregnancy seems low but the urologist is

certain that he sees too many. The problem is never to be minimized. Calculi of the size that can pass spontaneously are a fortunate occurrence compared to obstructive calculi in the upper ureter and calculi in the renal pelvis with severe pyelonephritis or pyonephrosis. Chemotherapy and antibiotics permit a certain amount of delay, but not infrequently surgery must be carried out during almost any stage of pregnancy.

In addition to the usual obstructive and suppurative processes which can impair or destroy kidney function, calculus disease complicating pregnancy presents special problems and considerations, such as viability of the fetus during the stage of pregnancy; general condition of the gravid patient; renal function as related to toxemia of pregnancy; obstruction and bacteriuria occurring in many puerpera. Evaluation of these factors and exercise of clinical judgment are essential. Removal of stones in the pelvis and calyces may usually be postponed. A stone in the ureter during the first trimester may be manipulated successfully or extraperitoneal ureterotomy can be performed, if necessary. During the last trimester, stones impacted in the lower ureter may be handled conservatively. Unless major complications occur it is better to temporize and await the viability of the fetus. Interruption of the pregnancy due to calculus disease is rarely necessary.

Several cases are reported in which these principles were followed without interruption of the pregnancy.

CASE TWO

A 24-year-old gravida 1, para 1, was admitted to the Perth Amboy Hospital on October 8 with a long history of dull, aching pain over the right lumbar area, radiating to the epigastrium, compounded by urgency, frequency, dysuria and burning on urination, with microscopic pyuria, periodically for many years. This girl had been seen four years earlier, when she was 19, by the authors. At that time, we had made a diagnosis of chronic right pyelitis with pyelectasis. This was due to congenital malrotation of the right kidney with uretero-pelvic obstruction. Five years later she delivered a normal baby, with minimal right kidney disturbance during her pregnancy. She was admitted to the hospital on October 8 with a large calculus pyelonephritis which apparently had developed prior to her pregnancy. Intravenous urography revealed a normal left upper urinary tract along with a non-functioning large right kidney that presented a massive stag horn calculus in the right renal pelvis. A right nephrectomy was done the next day and she made an uneventful recovery. She has been well since surgery and has presented no urinary complaints since that time.

This case demonstrates a normal delivery in the presence of calculus disease which was later successfully treated by nephrectomy.

CASE THREE

A 35-year old female was admitted to the Perth Amboy General Hospital with severe pain over the left renal area and left lower abdominal quadrant. She had vomiting, urgency and frequency of urination of several days' duration. This patient had delivered her first and only child four months previously by cesarean. We saw her in her seventh month of pregnancy, some six months ago, for chills, fever and pain over the left renal area and microscopic pyuria. Intravenous urogram at that time revealed a poorly functioning left kidney with two calculi in the area of the left renal pelvis, each about 1 centimeter in diameter. She was treated conservatively with antibiotic therapy and several months later was delivered of a normal baby by cesarean.

On this most recent admission, an intravenous pyelogram disclosed a left moderate hydronephrosis and two ureteral calculi—one in the upper ureter and the other in the lower third of the ureter on the left side. Each stone was the size of a large pea. Apparently these calculi were the same stones that had been previously noted in the kidney during her pregnancy. The right upper urinary tract was within normal limits.

Five weeks later, a left upper uretero-lithotomy, through a lumbar approach, was carried out to remove the upper left ureteral calculus. Left lower uretero-lithotomy was then done through an abdominal approach during the same operative procedure to remove the left lower calculus. She made an uneventful recovery and was discharged from the hospital on the 18th postoperative day, in satisfactory condition. She has been well post-surgically and has presented no urinary complaints since her left ureteral surgery.

This was the only pregnancy after ten years of marriage. For this reason we were conservative in our approach. She had a severe calculus pyelonephritis during her seventh month. A normal baby was delivered. Five

months later, the two calculi were removed surgically.

CASE FOUR

A 33-year old gravida 3, para 2, was admitted to the Perth Amboy General Hospital in her seventh month of pregnancy with severe sudden onset of knife-like pain over the left renal area, radiating to the left lower abdominal quadrant. She had vomiting, urgency and frequency of urination of 24 hours' duration. Intravenous urogram at that time revealed a non-functioning left kidney, due to an impacted obstructive calculus in the left ureter. The right upper urinary tract appeared relatively normal. The next day, a left high uretero-lithotomy through a lumbar approach was carried out. She made an uneventful recovery and was discharged from the hospital on July 18. Several months later, the patient had a normal delivery. One year later she was readmitted complaining of severe pain in the right renal area, associated with vomiting, chills and fever. Intravenous pyelogram then revealed a non-functioning, enlarged right kidney with a calculus in the renal pelvis. The left upper urinary tract was observed to be relatively normal. One week later, a right nephrectomy was done for a massive calculus pylonephrosis of the right kidney. She made an uneventful recovery and was discharged from the hospital ten days later in satisfactory condition. She has been well since surgery with no evidence of recurrent calculus disease of the urinary tract.

Here ureterotomy was necessitated by a ureteral calculus with sepsis and a non-functioning kidney. A normal baby was delivered two months later. One year later, this stone-forming patient had a non-functioning right calculus pyonephrosis, and nephrectomy had to be done. The other kidney (earlier threatened by an obstructing ureteral calculus) is now carrying on normal function made possible by the surgery done during the pregnancy.

CASE FIVE

A 20-year old gravida 1, para 1, was delivered by cesarean at the Perth Amboy General Hospital. Indication for the section was chronic nephritis with blood pressure of 180/110, elevated blood chemistry and progressive toxemia. Five days following cesarean, the obstetrician palpated a soft fluctuant grapefruit-sized smooth, freely movable mass in the left upper quadrant. An intravenous urogram was done and a large non-functioning renal shadow was noted on the left side. The right upper urinary tract revealed a fairly advanced pyelectasis and caliectasis. It was decided at urologic consultation to observe the patient for one month and then readmit her for a second intravenous urography and retrograde pyelography. On readmission the intravenous urogram revealed marked reduction of the right pyelectasis and ureterectasis. There was no function of the left kidney. A large mass was noted over the renal area on the left side. Cystoscopy and left retrograde pyelography showed a massive left hydronephrosis from a congenital obstruction at the left ureteropelvic junction. In all likelihood a left nephrectomy will have to be done. She was discharged from the hospital to return at a future date for left renal surgery.

This demonstrates that unilateral, massive hydronephrosis does not interfere with pregnancy. Surgery will be done later.

CONCLUSION

DURING pregnancy, good urologic care will aid the obstetrician in his responsibility toward mother and baby. Though relatively infrequent, urologic complications may call on the combined knowledge of urologist, internist, and obstetrician. Their joint efforts have resulted in survival of some women and babies whose lives would otherwise have been lost.

DISCUSSION

DR. MORRIS GOTTLEIB: Of all the complications of pregnancy, this paper deals with probably the most important, and perhaps the commonest. All of us have most likely been faced with such complications. This is not surprising considering the close anatomic, embryologic, physiologic and endocrinologic relationships of the reproductive and urologic tracts.

The authors have not narrowed their interests purely to the specialty of urology. They show understanding of the obstetric problems as related to urology. Dr. Kramer rightfully spends considerable time in the discussion of acute renal failure. In this grave complication, meticulous attention to management may spell life or death.

Pregnancy after removal of a kidney is common enough to warrant discussion. Such women do perfectly well if the remaining kidney is normal. On the other hand if it is the seat of chronic nephritis, irreparable damage may result from the additional strain incident to pregnancy. In such

women, the development of toxemia or urinary tract infection must be regarded as more serious than in a patient with two kidneys. Therefore, a thorough evaluation of the remaining organ and its capabilities is essential. Should it be found unsatisfactory, contraceptive practices should be advised. In the unintelligent woman, sterilization may be justified. Where the pregnancy is allowed to continue, careful monthly chemical and kidney function tests must be made to ascertain that the single kidney is functioning satisfactorily. If the patient is suffering from chronic nephritis, abortion should be induced early or premature labor should be induced with the first sign of development of toxemia or pyelitis.

Recent papers may throw some light as to the prophylactic management of pyelitis of pregnancy, such as reported in the *New England Journal of Medicine* by Finnerty and his colleagues. They discuss the incidence of unsuspected urinary tract infection in normal pregnant and toxemic patients. Bacteriologic studies were done on 202 asymptomatic pregnant patients. One hundred and two (suspected of having toxemia) showed proteinuria, whereas 100 patients were entirely normal. The urine of 25 of the 102 patients with proteinuria grew organisms usually considered pathogenic with colony counts greater than 100,000 bacterial per milliliter. There was positive Gram stain on the unspun urine in 24 of 25 pregnant patients.

The urine of 14 of the 100 normal pregnant patients showed organisms usually considered pathogenic for the urine, with colony counts of more than 100,000 bacteria per milliliter. A positive Gram stain on unspun urine was noted in all 14 of these patients.

These data suggest that if genito-urinary infection is not to be overlooked, a urine culture and colony count (a Gram stain on unspun urine) must be done on all pregnant patients with proteinuria and incorporated in the prenatal routine for all pregnant patients.

254 State Street

Syphilis and Homosexuality

The male homosexual, low man on the social totem pole, makes a substantial contribution to the nation's rising syphilis rate. In the June 1962, *GP*, a Los Angeles physician says that there has recently been "a phenomenal increase" in homosexually-transmitted venereal infections.

Dr. John D. F. Tarr adds that in Los Angeles, the soaring syphilis rate "is due to homosexual practices." During a recent four-year period the number of known syphilis cases in the city climbed from 3 to 17 per 100,000 people.

Dr. Tarr points out that homosexuals "are notoriously imaginative in their sex behavior" and for this reason, venereal disease lesions may be found anywhere on the victim's body. Unfortunately, he adds, homosexuals seldom understand the urgent need for routine venereal disease examinations. "Many are lulled into a false security because of the mistaken belief that venereal disease, like pregnancy, is an exclusive complication of heterosexual relations.

"Other attitudes of the homosexual complicate the physician's task. When the homosexual becomes aware that he has acquired a venereal infection, he is faced with a dilemma which does not confront his heterosexual counterpart. He is reluctant to incriminate himself or his partners by supplying information concerning his sexual practices, for in so doing he admits to behavior which could result in police arrest. The homosexual is also haunted by "the ever-present specter of blackmail." He adds: "We are not aware of any reported cases of venereal infection transmitted between homosexual females."

A major problem, Dr. Tarr says, is breaking the chain of transmission. He notes that the aggressive male homosexual "often achieves a fantastic number of sexual contacts." One of Tarr's patients, suffering from secondary syphilis, named 48 different sexual partners, living in different areas.

Tarr concludes that it's a mistake to believe that venereal disease is under control. He adds: "Treatment and control . . . are still extremely important to society in general and the family physician is in the front line of attack."

Between 1956 and 1960 the new syphilis rate per 100,000 has increased in New York from 7 to 27; in Washington from 4 to 57; in New Orleans from 3 to 62, and in Miami from 14 to 64.

William O. Wuester, M.D.

Elizabeth

Experience with Macrocystic Disease of the Breast*

Benign macrocysts should not be radically and routinely removed in a panicky effort to forestall a malignancy according to this survey of an unusually large collection of women with macrocystic disease of the breast.

There appears to be such a diversity of opinion about the treatment of macrocysts of the breast that 250 of these cases were analyzed with the hope of reaching some basic conclusions. The clinical material covers 20 years. It includes both private and clinic cases. Many of the patients were lost to follow-up or were referred to their physicians after a time elapse when cysts were no longer clinically palpable. However, sufficient data on a generally satisfactory follow-up period are available.

The average age of these patients was 45.5 years on initial visit; the youngest was 13½; the oldest was 69. Pregnancy history is shown in Table 1, as follows:

TABLE 1.

Gravida	No. of Patients	Para	No. of Patients
0	78	0	90
1	59	1	56
2	62	2	72
3	26	3	20
4	14	4	6
5	3	5	2
6	4	6	3
7	3	7	1
8	2	8	0
9	1	9	0
	250		250

One hundred and twenty never nursed; 74 nursed at least one month with the average nursing period 4.9 months.

Thirty-three had had irregular menstrual periods; 23 had had hysterectomies but it was not ascertained whether ovaries were removed in all cases. One patient with previous hysterectomy had a total of 54 cysts.

Most of the patients were in the fourth decade of life; 138 were between 40 and 49 years of age. The age span varied from 13½ to 69. The youngest patient had a cystic mass at the areolar border which on aspiration yielded cloudy hemorrhagic fluid. Examination of the removed fluid revealed atypical cells. Excision of the residual thickening confirmed a diagnosis of intra-cystic papilloma approximately 1 by 1½ centimeters in size. This is the youngest I have seen.

For years I had thought that cystic disease was a self-limiting process rapidly diminishing almost immediately after the menopause. In 91.8 per cent of the patients studied this was true; but 23 or 9.2 per cent persisted in having cysts after the age of 55.

TABLE 2.

MACROCYSTS BEYOND THE AGE OF 55

Age	No. of Cases	Age	No. of Cases	Age	No. of Cases
56	7	61	1	66	0
57	3	62	1	67	0
58	4	63	0	68	2
59	2	64	0	69	1
60	11	65	0	70	0

*This paper is from the Wuester Clinic and the Department of Malignant and Allied Diseases of the Elizabeth General Hospital, Elizabeth, New Jersey.

This might indicate a continued high level of estrogen in these patients either from ovarian or adrenal origin. All post-menopausal cysts were benign. Of 205 patients with cysts, Frantz [1] found only four after the menopause (2 of 60, 67, 69 years).

In 1930 Goormightigh and Amerlinck [2] reported reproducing cystic disease by injection of estrogen in ovariectomized mice. Estrogen stimulates mammary epithelium and also causes dilatation of the ducts and cyst formation. Variations may be due to individual susceptibility.

NUMBER OF CYSTS

These 250 patients had 413 cysts clinically large enough to aspirate on the first examination and obtain fluid without difficulty. Many descriptions of the breasts referred to innumerable small shot-like cysts easily palpable on initial exam. This is typical of the disease. On subsequent visits we found 739 cysts clinically large enough to aspirate. Seven patients had over 20 cysts on re-visits; one had 54; and 149 patients had cysts on return visits. But 101 had no cysts on return visits. If we limit the recurrence of the cyst after aspiration to the same area, 168 (or 67 per cent) did not recur; 82 (or 33 per cent) did. It is therefore concluded that *simple aspiration of macrocysts was sufficient to eradicate the cyst in many instances* and allow repeated aspirations in the remaining group.

SIZE AND COLOR

The largest cyst was 75 cubic centimeters. Four were over 60 cubic centimeters; 87 over five cubic centimeters in 80 patients. The largest cyst found in any subsequent visit contained 28 cubic centimeters. Color varied from slightly cloudy yellow or white to green-black to hemorrhagic. The degree of cloudiness varied with the amount of cellular debris in the fluid. Color was not a guide as to the presence of malignancy except in those cases to be mentioned later where bloody fluid was obtained from primarily malignant tumors undergoing cystic degeneration.

PREVIOUS BREAST SURGERY

Thirty patients reported a total of 42 local breast operations prior to the initial visit. Two had had as many as four local operations for breast cysts. One patient had a previous radical mastectomy, but 47 had been advised to undergo local excision and frozen section. Most of these had only a local breast examination without a complete examination or any attempt at determining the possibility of pelvic pathology prior to hospital admission.

RECURRENCE AFTER ASPIRATION

Sixty-eight per cent did not recur in the same area aspirated. Thus, the single simple procedure of aspiration was sufficient in two of three cases. In 82 patients (32 per cent), there was recurrence in the same area but they were amenable to repeated aspirations at 6 to 12 week intervals until the cysts failed to refill. This repeated aspiration may be carried over many months or until the effects of the menopause cause a cessation in activity.

Time interval from day of aspiration to refilling of the cysts (when they recurred in the same area) was variable. Among these 82 patients, the interval varied from 3 days to 30 months. Routine but continued clinical observation is essential. Patients should be instructed in self-examination after each menstruation and at definite intervals after menopause when more serious tumors have their greater incidence. Most patients, if properly instructed, cooperate in this procedure. Unfortunately, all do not do so.

1. Frantz, V. K. *et al.*: Cancer, 4:762 (1951).

2. Goormaghtigh, N. and Amerlinck, A.: *Bull. Assoc. franc. pour l'Etude du Cancer,* 19:527 (1930).

PAPILLOMA

PAPILLOMATA are of frequent occurrence in ducts outside macrocysts, and are usually associated with blunt duct adenosis and proliferation of the duct epithelium. We have had only one case; a girl of 13, who had a true, well-formed 10 by 15 millimeter intracystic papilloma. Diagnosis of this was made preoperatively by our pathologist, Dr. A. R. Casilli. He did this on a small needle aspiration of the cystic fluid. It can be considered an extension of the papanicolaou technic providing in most instances, more adequate cells for analysis.

HORMONES

DEPOTESTOSTERONE was utilized in 22 patients who were actively menstruating and who were forming multiple cysts at short intervals. Doses of 25 milligrams every week for eight weeks were used. It was felt that dosage beyond this ran the risk of masculinizing changes. Although little clinical change was seen in the course of the disease we did note a softening of those breasts particularly tense and painful. There was considerable relief from the pain. One of the patients receiving testosterone subsequently developed carcinoma of the breast. No causal relationship is implied.

X-RAY STERILIZATION

BECAUSE cystic disease of the breast is usually limited by the menopause we gave x-ray therapy to the ovaries for sterilization purposes in two patients. In both instances excellent results were obtained with a gradual disappearance of cystic changes over a six month period. This treatment was reserved for rather extreme cases. We would not hesitate to use this method in carefully selected patients but would not recommend it as a routine.

SUBSEQUENT CARCINOMA

A REVIEW of the 250 cases revealed that eight patients (3 per cent) with cystic mastitis developed carcinoma in the same or opposite breast; *but in no case was the carcinoma in the area where a macrocyst had been noted and aspirated.* These patients had been followed 5 to 20 years. Lewison and Lyons[3] followed 153 patients over 5 years. Four of these developed cancer: a ratio of 2½ per cent.

The summaries of these eight cases are listed in brief form:

1. Age 49.
   1943—*Right Breast*—1½ by 1 cm. cyst 9 o'clock 3 cm. from nipple. Fluid benign.
   1959—*Right Breast*—5 by 5 cm. mass 5 o'clock. Aspiration showed malignancy and radical mastectomy was done. The laboratory reported adeno-carcinoma with axillary metastasis, grade III. She died in 1960.

2. Age 49. In 1953 there was a benign cyst areolar border 11 o'clock, right breast. In 1957, the left breast was removed. She had an adeno-carcinoma with axillary metastasis, grade III. She died in 1959.

3. Age 33. In 1948, in the right breast, there was a 5 cm. benign cyst at 9 o'clock, 6 cm. from nipple. There were multiple cysts up to 42 cc. in both breasts. In 1951, from the left breast 44 cc. fluid from large cyst with residual thickening. Positive cells. Later a radical mastectomy was done. She had an adeno-carcinoma, grade III positive nodes. She died in 1953 with diffuse metastases.

4. In 1941, this 52-year old woman had clear nipple discharge (*right*). In 1944, there was an excision of an intraductal papilloma *right breast* at 2 o'clock. In 1947, *right breast*: cyst areolar border 10 o'clock. In 1948, there was found in the *right breast*, a mass at 10 o'clock 7 cm. from nipple. Aspiration was positive. She had an intraductal papillary adeno-carcinoma II. Negative nodes. She died in 1951.

5. A 39-year old woman had mastitis, *left breast*, 3 o'clock 5 cm. from nipple. Local excision was done in 1951. The laboratory reported a sweat gland adenoma. In 1953 she had cysts, *left breast* at 12 and 2 o'clock. Aspiration of 3 cc. and 4 cc. benign fluid. Then in 1956, *right*

3. Lewison, E. F. and Lyons, J. G.: Archives of Surgery, 66:94 (1953).

breast: 20 cc. cyst near axilla. Benign fluid. In 1957, *right breast*: multiple 1 to 4 cc. cysts. Benign fluid. Later in 1957, *left breast*: multiple cysts. Diffuse nodularity both breasts with increased tension and firm mass (fibrous right breast). Depotestosterone 50 mgm. B. I. W x 8. In 1959 she had multiple cysts at the *right breast* (3 cc.) 12 o'clock. In 1960 there was a solid 15 millimeter mass at tail of *left breast*. Aspiration positive. A radical mastectomy was done. Adenocarcinoma was reported. Nodes negative.

6. Age 51. In 1948 at the *right breast*: cyst areolar border 3 o'clock. Seven years later, there was a firm mass 4 o'clock, 8 cm. from nipple. At radical mastectomy, a scirrhous carcinoma was found. Nodes were negative.

7. Age 45. In 1947: 80 cc. cyst lateral position at breast. Fliud benign. Then in 1949 *left breast*: 4 by 4 cm. solid tumor 2 o'clock, 5 cm. from nipple. Aspiration positive for carcinoma. Radical mastectomy was done. The laboratory reported adenocarcinoma. Nodes were negative. As of July 1960 there was no evidence of disease.

8. Age 41. In 1946, at the *right breast*: fibroadenoma, 12 o'clock, 5 cm. from nipple. In 1952, *right breast*: 12 cc. benign cyst at 2 o'clock, 5 cm. from nipple. In 1955, *left breast*: mass in scar from abscess 23 years previous. The biopsy was positive. Radical mastectomy was done in 1953. This showed adenocarcinoma with positive nodes. As of 1960, there was no evidence of disease.

In no case have we seen (on pathologic examination) a carcinoma in a macrocyst. Foote and Stewart [4] studied 1200 cases of carcinoma and found that only 2½ per cent had a past history of operatively proved cystic disease. In Presbyterian Hospital (N.Y.) only 9 patients (0.6 per cent) of 1544 cancer cases had proved cystic disease prior to the carcinoma. Bloodgood [5] stated that of 500 cases when the breast was the site of cysts, only five had cancer. Haagensen [6] asserts that carcinoma, when it did occur, was as frequent in the opposite breast as in the affected breasts. Our listed cases confirm this. Frantz [1] analyzed 225 autopsies. Grossly evident cysts were present in 19 per cent with an additional 34 per cent showing microscopic cystic disease; therefore, 53 per cent had the disease in ages 19 to 80. Foote and Stewart [4] in detailed examination of breast cancer found gross (one mm. or more) cysts in 27 per cent. One must agree with Haagensen's conclusion [6] that the "evidence concerning the relationship of cystic disease to carcinoma must be interpreted with the basic fact in mind that the microscopic form of cystic disease exists in the great majority of the breasts of the adult female."

During the period to 1960 covered in the report of the macrocystic cases the clinic registered 1018 proved carcinomas of the breast. At the time of the initial examination, only two had had macrocysts in one breast and carcinoma in the same or opposite breast. There is no way of knowing how long these two were co-existant. Here are their stories:

A 50-year old woman had 2 cysts in her left breast in 1952. They were at 11 o'clock and there was a solid mass at 6 o'clock. Aspiration was positive. In May 1952 a mastectomy was done with axillary dissection. The laboratory reports adenocarcinoma. She died of kidney disease in April 1953.

A 44-year old woman was examined in 1960 and had multiple cysts in the left breast. There was a 2-centimeter mass in the right breast. Aspiration was positive. After radical mastectomy, a diagnosis of acinar carcinoma was made. Nodes were negative.

In the same series of cases, three patients presented themselves with a clinically cystic rubbery mass, which on aspiration, yielded bloody or suspicious fluid with a residual thickening suspicious of cancer. Either through an aspiration of the residual mass or an examination of the bloody aspirate a diagnosis was made.

One was an 81-year old woman who was examined in 1952. In the left breast, firm skin was attached to a mass at 3 o'clock with bloody nipple discharge. On the right there was a cystic mass at 3 o'clock, yielding bloody fluid. Aspiration was positive. A bilateral simple mastectomy was done with low axillary dissection. Adenocarcinoma was reported (on the left) by the laboratory. Nodes were negative. On the right she had sclerosing and infiltrating malignant papillomatosis. When last heard of in 1957, she was alive at age 86 with no evidence of disease.

Another was a 29-year old woman who, in 1959, had a mass at 5 o'clock in the left breast with

4. Foote, F. W. and Stewart, F. W.: Annals of Surgery, 121:197 (1945).

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residual thickening. This proved to be an adenocarcinoma, and a radical mastectomy was done in March 1960.

The last case in this series is the one listed as number 3 in the first group above.

In all three of these women, the cyst was due to degeneration of a carcinoma; the carcinoma did not develop in the cyst.

CLINICAL PATHOLOGY

Macrocysts may be thick or thin-walled. They are usually multiple with large single cysts. Meticulous examination of the breast will reveal a diffuse nodularity explained only by the presence of additional fibro-cystic changes in the breast. The degree of disease palpable depends on the structure, consistency, pliability, and variable amount of fat present in the breast. The engorgement associated with the pre-menstrual phase must be considered. Pain is a frequent complaint usually pre-menstrually, and especially with a short history of rapid enlargement of the cyst. The disease may be limited to one area of the breast as a conglomerate collection of multiple cysts simulating carcinoma to palpation but usually without the true skin attachment one would expect with lesions of this size. Microscopically, it is common to see all phases of development of the cyst. One may see blunt duct adenosis, variable degree of acinar hyperplasia, proliferation of the apocrine epithelium of the ducts, intraductal papillomatosis, and cysts filled with dead cells. The formation of these cysts is due to epithelial desquamation in the acini and ducts forming an irritant coalescing as they enlarge with secretion, gradually flattening the epithelium of the cyst lining until it may be non-existent. The variable character of the fluid would indicate that it is a secretion, not an inflammatory process. Few polyps are normally seen in the centrifuged fluid and when they are seen the resultant thickening in the area after removal of the fluid is more pronounced, indicating an inflammatory or "mastitis" process in this group of cases. We have seen this immediate thickening subside in a few weeks after cyst evacuation, and therefore, have hesitated to advise immediate surgical excision of the thickening present after aspiration unless it suggests more malignant characteristics than one would expect with residual thickened fibrous breast tissue. We do additional aspiration of any questionable thickening with a regular Number 17 gauge needle after initial evacuation of the cyst with the Number 21 needle.

Excluding the proved cases of carcinoma, there were 37 patients where the clinician felt there was residual thickening of sufficient amount to note it on the record. In 14, there was a recurrence of the cyst in the same area. The breasts of 9 patients with residual thickening were suspicious enough (either by aspiration of the solid residual component or by palpation) to be admitted to the hospital for frozen section. Final diagnosis in these were fibro-cystic disease (5); stromal fibrous (1); cystic adenosis (1); plasma cell mastitis (1); and intracystic papilloma (1).

CONCLUSIONS

1. The result of this survey was to show that the wanton removal of benign macrocysts "to make sure it is not cancer" is unnecessary. The disease is a physiologic variation common in almost all breasts to a greater or less extent. If one must justify a policy requiring surgery in *all* these conditions, the logical decision would be the entire removal of both breasts by simple mastectomy. The removal of a contained sac of fluid from the breast does not cure the disease. It does not prevent cancer which originates outside the cyst itself. It does offer to the mechanical surgeon unfamiliar with the normal physiology of the breast, a palpable excuse, poor as it may be, for another operation.

2. If this report does nothing but call attention to this problem and is helpful in allaying the fear, anguish, and financial expense incident to any women contemplating breast surgery, it will have served its purpose.

815 Salem Avenue

William H. Ainslie, M.D.

Arthur S. Dicker

Metuchen

A Rapid Serum Pregnancy Test

A simple, swift and accurate pregnancy test is offered using blood rather than urine. Since the doctor draws the blood, there is no chance of substitution of specimens.

Many procedures have been developed in the search for a rapid, accurate pregnancy test. Ascheim and Zondek [1] in 1928 were the first to use animals successfully. Their test used mice injected with urine and then sacrificed. Results were interpreted as either positive or negative. Friedman [2] in 1932 modified the test by using young rabbits. As in the earlier test, the procedure took 24 hours. Salmon [3] in 1942, used the rat. This test could be read in 12 hours. The use of human blood serum in place of urine was introduced by Siddall [4] as early as 1928. All these modifications have been interpreted either as positive or negative after inspection of the gross appearance of the ovaries. Other animals, such as *xenopus laevis* [5] and *rana pippiens* [6] have been used with variable success. Skin tests for pregnancy have met with little success.

MATERIAL

This paper presents our experience with a modified A-Z test using blood serum injected into a rat. Our modifications have been concerned with the amount of serum and the interpretation of the rat ovary results. A total of 626 patients with suspected early pregnancies had blood samples drawn at their first visit. Positive results were recorded in 531 of the tests. *Every one of these was subsequently verified to be pregnant.* (Table 1) Negative results were recorded in 57 cases. Two uneventful pregnancies were subsequently found in this group but both demonstrated positive results with repeat tests two weeks later. Another two in this negative result group aborted within a week of the tests. (Table 2) The remaining 53 cases were proved to be not pregnant. Doubtful results were recorded for 38 tests (Table 3); and 15 of these either aborted or threatened to abort subsequently (39 per cent). An additional three cases of this group later proved to be not pregnant. The remaining 19 subsequently gave a positive result. All doubtful or negative tests were repeated within two weeks. Reports of these repeat tests are not included in our results. Ninety-two per cent of the tests produced definitive results. Only two errors (0.34 per cent), both on the negative side, were found among the definitive results; and 7.5 per cent were interpreted as doubtful.

METHOD

Blood samples were drawn during routine office visits by venipuncture. Each blood specimen was placed in a clean, dry tube and refrigerated. At the laboratory, each specimen is

centrifuged for 10 minutes at 3,000 revolutions per minute. The serum is then drawn off. A young female rat weighing between 35 and 40 Grams is prepared by etherizing. Then 0.2 cubic centimeters of the serum is injected subcutaneously over the abdomen. The rat is killed by gas at the end of eight hours. Its ovaries are then examined. We allow the ovaries a 5 to 10 minutes exposure to air before making a final reading. Any time between 6 and 24 hours may be used; optimum time seems to be 8 hours.

A *positive* result is reported where the ovaries are found to be enlarged 2 or 3 times



Figure 1: Typical positive result

normal size and hyperemic. The fallopian tubes may show moderate or extensive edema. Both ovaries must be involved without variation (Figure 1).

A *negative* result is recorded where no changes can be found from the pre-injection state (Figure 2).

A *doubtful* result is reported if we find only very slight edema, almost pallid in appearance, with some extremely mild injection of the small veins on the surface of the ovaries. Hyperemea is not found, although a mottled, dirty gray discoloration of the ovaries is sometimes present. Only one ovary may be involved (Figure 3).



Figure 2: Typical negative result



Figure 3: Typical doubtful result

ADVANTAGES

THE test can be drawn at any time without preparation. It can be taken without arousing suspicions. Substitutions of specimens is prevented. Only a small amount of the specimen is utilized (0.2 cubic centimeters of serum). Rapid results can be obtained (8 hours). A high degree of accuracy has been demonstrated. This test may be a guide to the condition of the pregnancy.

TECHNICAL SUGGESTIONS

(a) For injection a tuberculin syringe is of prime importance.

(b) Do not kill the rats with chloroform; this substance may give false positive results.

(c) Use a 24 gauge needle in making injection as there is a tendency for the serum to exude from the needle site. As an added precaution pinch the site of injection between thumb and index finger.

(d) Make sure that rats used in the test do not have salmonella infection. This is readily recognized by a yellow diarrhea.

(e) Hemolyzed serum may be used; serum stored at room temperature up to 48 hours may be used.

(f) In opening animal do not cut into the liver. The liver bleeds freely and floods the abdominal cavity, obscuring the ovaries.

SUMMARY

1. A new modification of the Ascheim-Zondek test has been presented. It uses only 0.2 cubic centimeters blood serum injected into one or more rats.

2. A high degree of accuracy has been demonstrated for this test. A "Doubtful" classification has been introduced for evaluatting the results. A "doubtful" result should be viewed with suspicion of potential trouble.

TABLE I.

POSITIVES

626	patients tested
531	positive on first test
563	proved pregnancies in this group
94.3	per cent accuracy of initial test
557	positives on repeat test
98.9	per cent accuracy on repeat tests
0	false positives

TABLE 2.

NEGATIVES

57	negatives on first test
2	viable pregnancies in this group
2	aborted within two weeks
53	were not pregnant
3.5	per cent false negatives on first test

TABLE 3.

DOUBTFULS

38	doubtful results in first test
4	of these subsequently aborted
11	threatened to abort
3	were not pregnant
19	were normally pregnant
24	positive on repeat test
6	gave only repeated doubtfuls

73 Amboy Avenue

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Trustees' Minutes

AUGUST 19, 1962

A regular meeting of the Board was held at the Executive Offices on Sunday, August 19, 1962. A summary of the significant actions follows:

Tribute to Doctor Bowers . . . Approved the President's letter of tribute for inclusion in a commemorative anthology to be presented to Dr. F. Clyde Bowers—former President of MSNJ—at a testimonial dinner tendered him by the people of Mendham.

1962 Diabetes Detection Week . . . Agreed to co-sponsor—together with the State Department of Health, the New Jersey Association of Osteopathic Physicians and Surgeons, and the New Jersey State Dental Society—the 1962 Diabetes Detection Week (November 11-17).

Utilization of Available Nurses . . . Appointed Dr. Irving M. Levitas, Chairman of MSNJ's Special Committee on Nursing Education, as official representative on an advisory committee to study the utilization of available nurses, under the joint sponsorship of the New Jersey State Department of Institutions and Agencies and the State Department of Health.

Post-Graduate Teaching Program . . . Agreed to co-sponsor—with the State Department of Health—a Graduate Teaching Program, under the aegis of the Academy of Medicine of New Jersey. On request, the Academy would send to an interested hospital a group of five physicians who would lead a teaching discussion, at post-graduate level, on topics listed by the Academy or of the staff's choosing.

Mass Anti-Polio Immunization . . . Approved the statement issued by the Executive Committee commending the Bergen County Medical Society for its proposed program, in conjunction with other agencies of Bergen County, to effect the mass immunization of the citizens of Bergen County against paralytic poliomyelitis by means of the administration of Sabin Oral Vaccine.

Vendor Payments in Welfare Cases . . . Supplied to the members of the Subcommittee on Public Medical Care of the Council on Medical Services the following statement from the Division of Welfare of the State Department of Institutions and Agencies:

> It is the desire of the Division of Welfare to strive for the utmost in simplicity and practicability as to program content and required forms, consistent with the need to provide useful information for operating statistics, auditing and accountability of expenditures from public funds.
>
> The advice, counsel and active participation of the Subcommittee of the Council on Medical Services are most welcome in the development of an organized health care program for public assistance recipients and those persons eligible for care through other public welfare service programs.

Distinction Between Blue Cross and Blue Shield . . . Received a report from Hospital Service Plan of New Jersey with reference to Resolution #9 (Mercer County), which states:

> Considering the statements made in the preamble of the resolution, a press release was issued by the Blue Cross Plan for publication April 12, 1962, in which it was pointed out that the rates of New Jersey Blue Cross Plan only were increased. The press release further points out that the administrative expense of New Jersey hospitals, chiefly payroll, was a basic reason for the necessary increase, and specifically credits the Medical profession with cooperation in endeavors to keep the costs of hospitalization within bounds. This was gone into even further during the public hearing before the Commissioner of Banking and Insurance on April 12th.
>
> As to the desirability of separate billing for Blue Cross and Blue Shield, we respectfully point out that the economical operation of both Plans would be adversely affected by such a step.
>
> Installation of separate billing would be a costly operation, in that it would necessitate the acquisition of new mechanical equipment to enlarge the volume of printed characters in the Electronic Data Processing system. For accounts which have not yet been converted to the Electronic Data Processing system's tape method, additional punch cards would be required. Greater storage space

and an augmented clerical staff would be needed to install and maintain a dual billing system such as that suggested by the resolution. The end result would be additional cost to the subscribers of both Blue Cross and Blue Shield.

In an effort to effectuate the purpose of the resolution, we have evolved a method of acquainting each individual subscriber with the fact that Blue Cross and Blue Shield are separately purchased, through means of a notice, which specifies the rates for each class of contract under each Plan. We believe that the general distribution of this card along with bills to our subscribers will clarify any misunderstanding.

HSP In-Hospital Tests . . . Received a reply from Hospital Service Plan of New Jersey with Reference to Resolution #12 (Camden County), which states:

We agree, as stated in the approval appended to Resolution #12, that it is highly desirable that physicians discuss the Blue Cross contract limitations with their patients before ordering examination and services.

The proposal by the Camden County Medical Society, that the attending physician be contacted for his opinion of the necessity of questionable tests prior to claim determination, is not practical, and we believe unnecessary, in view of the existing procedure.

If, following the review procedure, the attending physician wishes to protest the Plan's determination, our Medical Advisors will review the case again, and if they are still of the same opinion, an offer is made to the attending physician to send the case to The Medical Society of New Jersey Advisory Committee to review Medical-Surgical and Hospital Service Plan disputed claims.

To facilitate physicians' discussion with their patients of Blue Cross contract limitations before ordering examinations and services, we will prepare a statement covering the contract provisions and interpretations for dissemination to physicians and trust that The Medical Society of New Jersey will be able to distribute this statement. We will submit such a statement to you after the necessary clearances and approvals have been made.

Clinical Psychologists Under Civil Service . . . Called to the attention of the State Board of Medical Examiners (as well as to the State Civil Service Commission, the State Board of Control, and the Attorney General) the violation of the Medical Practice Act by the specifications for clinical psychologists in state institutions, and requested that immediate steps be taken to correct the situation. In the specifications for the several classifications for clinical psychologists, prepared by the New Jersey Department of Civil Service and its Chief Examiner in April 1962, there are included in the job outlines statements that these clinical psychologists will administer psychotherapy under direction of a supervisory officer. The Medical Practice Act does not permit psychologists to do psychotherapy even at the specific direction of a licensed physician.

AMA Annual Appointments . . . Authorized the President and Board Chairman to submit nominations to the AMA for Annual Appointments to membership on councils and committees and on editorial boards.

AMA-ERF . . . Noted that the AMA has scheduled two additional fund-raising mailings—one in September and one in November.

Social Security Coverage of Physicians . . . Agreed that a poll of the membership should not be undertaken at this time, and that the AMA be informed of the 1959 action of the House of Delegates—reaffirmed in 1961—approving the inclusion of physicians under Social Security and mandating New Jersey AMA Delegates to support any resolution favoring inclusion of physicians under the Social Security Program.

AMA Accreditation of Post-Graduate Medical Courses . . . Directed that an early issue of the *Membership Newsletter* carry the AMA's announcement that, beginning in 1964, the AMA will accredit post-graduate medical courses "to improve the quality of courses offered to practicing physicians."

Medicare Program . . . Approved execution of the 1962-63 Contract; approved Supplemental Agreement #8401, concerning a new joint directive setting forth the Board policies governing the implementation of the Medicare Program.*

Approved execution of the routine three-party forms for the release of the Medicare Contract* for the period ending June 30, 1961; approved execution of Agreement of Indemnity (to validate the contract renewal, a bond on behalf of MSA in the sum of $20,000 was required to support advances up to $100,000 for the program revolving fund).

Approved Supplemental Agreement #8402 as follows:

A. Addition of the following as authorized eligible services: Article 5, paragraph a—payment for poliomyelitis and influenza vaccines in maternity cases.

*This does not involve any specific financial arrangements between the Government and the New Jersey Program.

B. Addition of Article 15—Clarification of care payable with reference to cardiac catheterization and radiation therapy.

C. Article 5—Billing procedure amended for clarity.

Disposition of Body for Scientific Research . . . Approved proposed legislation—submitted by the Council on Legislation—to enable a person to will his eyes for scientific work, as well as the "entire body," or any member or part thereof.

Eye Health Pamphlet . . . Authorized the expenditure of $408.75 for printing 7,500 copies of the pamphlet "An Eye Health and Eye Screening Program for Schools" drafted by the Special Committee on the Conservation of Vision and approved by the Council on Public Health and the Board. With the cooperation of the State Department of Education, this pamphlet is to be made available to school personnel.

Physician-Hospital Relationships in New Jersey . . . Received a progress report from the Council on Medical Services concerning a recommended guide of relationships between physicians and hospitals. The Council agreed that a subcommittee should be appointed to review the material collected and to draft a guide for New Jersey based on the following points:

1. Responsibility of the physician to the hospital
2. Responsibility of the hospital to the physician
3. Relationship of the various specialties to the hospital and to other physicians
4. Relationship of the physician to the patient in or out of the hospital.

The following Subcommittee was thus appointed: Drs. Francis J. Benz, Chairman, Chatham; Durant K. Charleroy, Lawrenceville; Nicholas E. Marchione, Vineland; Joseph M. Gannon, Plainfield; Andrew C. Ruoff, III, Pompton Plains; and Mr. Robert M. Backes, Counsel, Consultant, Trenton.

State Division of Welfare . . . Approved the report of the joint meeting of representatives of the State Division with members of the Council on Medical Services, at which was agreed that: (1) Resolution #7 to the 1962 House of Delegates—advocating simplicity of records—be approved; and (2) a permanent subcommittee of the Council on Medical Services be appointed to work with the Division in the formulation of policies in a mutually agreeable workable program.

Public Assistance Recipients . . . Adopted the recommendations of the joint subcommittee (under the Council on Medical Services) appointed to work with the Division of Welfare, as follows:

A) *Pharmaceutical Services*—Amend Section G, Provisions of Drugs and Medical Supplies:

2. Prescription Policies

g. Drugs may not be dispensed after an interval of seven days from prescription date *unless the doctor has been contacted (by telephone).*

4. Non-Payment Items

b. The County Welfare Board will not allow payment for any of the following items, except as noted: (1) Dietary Reducing Preparations, etc. *such preparations to be specified.*

B) *Prescription Form*—Approved the form used in Burlington County—quadruple copies on carbon-impregnated paper, on which the physician is required to sign only once. The forms will vary slightly from county to county.

C) *Physician's Claim Form*—Simplified the form so that a single monthly billing could be limited to a specified number of visits without authorization; tentatively, the limit would be 5 visits per month for acute illness and exacerbation of a chronic illness and 2 visits per month for chronic illness.

D) *Home and Office Visits*—Maximum allowances have been increased from $3 and $4 to $4 and $5. Such allowances are not mandatory. Thus, some counties have increased their fees and others have not.

Public Educational Program . . . Approved the report of the Council on Public Relations—to which this Resolution #13 was referred—as follows:

Inasmuch as developments since the preparation and introduction of this resolution have demonstrated that the position of MSNJ and its component societies with reference to King-Anderson and Kerr-Mills legislation has been clearly, frequently, and adequately set before the public by various methods—particularly news releases consequent upon the recent annual meeting—there is no longer a need for the recommendations contained in Resolution #13.

PR Projects for 1962-63 . . . Approved the following continuing projects of the Council on Public Relations:

(1) Publication and distribution of:
   (a) JUNIOR HEALTH HINTS to schools and public libraries
   (b) HEALTH HINTS to the press, house organs, and other media
   (c) MEMBERSHIP NEWSLETTER
   (d) PERIODIC NEWSLETTER to cooperating agencies and individuals

(2) Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests, including:
   (a) 1962 Eye Health Screening Program
   (b) 1963 Annual Meeting

(3) Responsibility for the bestowal of the Golden Merit Award

(4) Responsibility for the press room at the Annual Meeting

(5) Maintenance of press clipping service for the Society's public relations features, releases, and press notices

(6) Continuance of consultative service in support of the public relations activities of component societies

(7) Encouragement of indoctrination program under the sponsorship of the component societies

(8) Preparation and distribution of a membership service kit

AMA Institute . . . Authorized the Executive Officer and the Chairman of the Council on Public Relations to attend the 1962 AMA Institute at the Drake Hotel in Chicago on August 30-31.

Implementation of Constitutional Amendment . . . Adopted the report of the committee appointed by the Board to consider the intent of the Constitutional amendment adopted by the 1962 House of Delegates affecting the apportionment of delegates for proper implementation by the county society.

The committee's report follows:

1. By use of the word "shall" throughout the amended paragraph, the regulation is mandatory.
2. Since the amendment did not include a specific effective date, it became effective immediately upon its adoption.
3. Stipulation of the number of delegates to which a component society is entitled is by regulation of the State Society; and development of the body of delegates in the proper number is the business of each component society.

The delegations of seventeen component societies will be affected by the amendment, and following a discussion of several approaches to the problem, the committee agreed that the easiest solution would be for the component societies to have their delegations resign and then to re-elect in the proper number.

The committee agreed to submit the following *recommendations* to the Board of Trustees:

1. If a component society has not evolved its own method of effecting the change, and advice is desired, we suggest that the component society call for uniform resignations of its entire delegation, and then follow-up with re-election of the new delegation in the proper number in conformity with the the amended provision of the Constitution.

2. To let the component societies know that the problem is not too complex, particularly in view of the fact that some delegates do not attend meetings year after year, we suggest that an absentee record be sent to the counties with indication that, upon request to the Executive Offices, they can obtain the names of the absentee delegates (if they have not kept the attendance records sent to them at the close of each annual meeting).

Traffic Safety . . . Received and noted the report of the Special Committee on Traffic Safety covering discussion on (1) Accident-Prone Drivers, (2) Governor's Conference on Traffic Safety, (3) Glare Recovery, (4) Assistance to the Division of Motor Vehicles, and (5) Re-Examination of Licensed Drivers.

Worker Health and Safety Act . . . Approved the report of the Special Committee on Industrial Health, for submission to the Governor's Advisory Committee on the Worker Health and Safety Act. It follows:

1. Provision should be made for public hearings on proposed regulations.

2. Empowering the Commissioner to make and promulgate rules and regulations, rather than giving this function to a professional board or committee, is contrary to accepted practice. It would be more appropriate for the Board to propose rules and regulations.

3. The obligations placed upon the owner throughout the proposed law are unrealistic. In many cases the owner—the one possessing legal title to real estate—does not have control or even the right to control the property. It would be more appropriate to impose these obligations upon the party in control.

Auxiliary Program . . . Approved the proposed program submitted by the Auxiliary, including the following new items:

Civil Defense—To support the program of health mobilization and the promotion of the medical self-help program; and to recommend specific literature on civil defense efforts to the membership with the approval of the county medical society.

Health Careers—To request advice of component societies concerning encouragement of Future Physicians' Clubs in high schools.

Legislation—To cooperate with the Council on Legislation; to urge county legislative chairmen to make full reports on legislative activities at county Auxiliary meetings; to cooperate with the State Public Relations Committee in supplying informative material.

A Workshop Series for Dietitians . . . Agreed to co-sponsor—with Rutgers University, the New Jersey Dietetic Association, and the New Jersey Hospital Association—the 1962 Fall Refresher Training Course in Diet Therapy.

Budget Account Transfers . . . Authorized the following transfers, in accordance with the Bylaws, Chapter X, Section 3 (a), for overexpended accounts as follows:

Treasurer	$ 137.98
Employment security taxes	58.45
Federal insurance contributions	130.68
Federal tax on employees	12.05
Insurance	80.48
Council on Public Health	129.84
Council on Medical Services	15.64
Medical JOURNAL operating deficit	16,040.22
House Committee reserve	2,429.62
Total	$19,034.96

AMA Lists of Physicians . . . Received and noted, in response to its inquiry, a letter from the AMA Executive Vice-President, as follows:

First, I should like to make it clear that there are many lists of physicians which are compiled and used by private entrepreneurs—they obtain these names and addresses from telephone directories and other sources. The existence and use of these lists means that a significant portion of the professional mail directed to physicians does not involve the official list maintained by the American Medical Association.

For many years, the AMA has maintained a directory of all physicians residing in the United States and its possessions. This list forms the basis for our membership records, for addressing official communications, and for mailing JAMA, the Specialty Journals, the AMA *News*, and *Today's Health* to physician members.

Also, it has long been the policy of the AMA to make this list available to outside parties who have a legitimate interest in communicating with physicians; in so doing, we are guided by the following policies:

1. All such communications must be germane to the practice of medicine in its scientific or socio-economic aspects, or of interest to the physician as a consumer.
2. All such communications must be free of contents which tend to mislead, misinform, or deceive physicians.
3. At the request of any physician, the American Medical Association will exclude his name and professional mailing address from lists made available to outside parties.
4. Outside parties using mailing lists furnished by the American Medical Association will be charged a service fee sufficiently large to reimburse the AMA for the costs incurred in compiling these lists and in keeping them current.
5. The American Medical Association will waive the usual service fee when the organization communicating to physicians is a professional medical or allied association and is recognized as such by the AMA.

SEPTEMBER 16, 1962

A regular meeting of the Board of Trustees was held at the Executive Offices on Sunday, September 16. Following is a summary of significant actions taken at that meeting:

Council on Public Relations . . . Appointed Dr. Earl L. Warren of Paterson to fill the unexpired term of one year of Dr. Aloysius P. Rieman of Jersey City—who resigned.

National Safety Council Safety Leadership Training Conference . . . Authorized Dr. William L. Sprout of Salem—Chairman of MSNJ's Special Committee on Traffic Safety—to represent the Society at the National Safety Council Safety Leadership Conference, to be held in Wilmington, Delaware, on September 20-21.

AMA Regional Conference on Aging . . . Authorized Dr. Matthew E. Boylan of Jersey City—Chairman of MSNJ's Committee on the Chronically Ill—to represent the Society at the Conference, to be held in Buffalo, New York, on November 1-2. The purpose of this Conference is to stimulate joint action, at state and local levels, between medical societies and other groups in the field of aging.

Auxiliary Committee on International Health Activities . . . Approved the request of the Woman's Auxiliary to establish a new chairmanship in New Jersey on International Health Activities. The purpose of this committee is to send medical books, supplies, drugs, and similar articles to needy foreign countries.

Volunteer Friendly Visitors . . . Referred to the Woman's Auxiliary a request from the State Commissioner of Health to cooperate in the new project—sponsored by the Division of Chronic Illness Control—to offer professional instruction to volunteers who are associated with state and local health welfare agencies, to prepare volunteers to visit the homebound chronically ill and elderly in New Jersey. (The training will be given without charge to the agencies or the volunteers in cooperation with Rutgers University Extension Division.)

Greisman vs. Newcomb Hospital, et al. . Accepted the detailed report and adopted the recommendations of Legal Counsel as follows:

The medical staff of Newcomb Hospital was named as party-defendant in a suit by a fully licensed osteopathic physician to obtain admission to the staff. The following is the conclusion in the lower court decision handed down on August 17, 1962:

> The judgment of this court is that summary judgment be denied as to the defendants and granted as to the plaintiff to the following effect and in the following manner:
>
> (1) the bylaws of the defendants which purports to require membership in the County Medical Society (Cumberland) as a basic requirement (preliminary qualification) for admission to the Medical Staff of the Newcomb Hospital is void *per se* and of no effect whatsoever as contrary to the public policy of our State.
>
> (2) the bylaws of defendants which purports to require the plaintiff, Dr. Greisman, to be a graduate of a Medical School approved by the A.M.A., *insofar as it applies to the plaintiff,* contravenes the public policy of this State and the true interests of justice.
>
> Therefore, the defendants Newcomb Hospital and the Medical Staff thereof are hereby ordered to proceed to issue and to consider the application for membership to the Courtesy Medical Staff by the Plaintiff, Dr. Greisman, in accordance with its remaining valid bylaws as if the plaintiff had fulfilled the basic requirements for admission to the Courtesy Staff pursuant to Article III, Section 1 of their respective bylaws.

It is the opinion of the Newcomb Hospital medical staff that the decision should be appealed, and the staff's counsel has suggested that MSNJ file a brief as *amicus curiae*. Mr. Backes' report on the case follows:

> I have reviewed the material in this case. The main issue was to determine the applicability of the principles of law set forth in the Falcone case. The court has determined that the ruling in the Falcone case is applicable to private hospitals which are affected with a public interest. That is, it was determined that the Newcomb Hospital, as the only general hospital open to the public within the convenient accessibility of the inhabitants of metropolitan Vineland, is an organization exercising entire control of the hospital facilities, services and practice of medicine therein in metropolitan Vineland. And, that since such control carries with it certain public responsibilities, the hospital is an organization concerning the operation of which the court should intervene to protect the public.
>
> The court further determined that the exclusion of Dr. Greisman from the hospital staff results in substantial injury to him, and therefore the bylaws requiring membership in the County Medical Society and an M.D. degree from a medical school approved by the A.M.A. are unreasonable and contrary to the public interest.
>
> Based on these determinations a summary judgment was granted Dr. Greisman ordering the hospital to consider the application of the fully licensed osteopathic graduate for *courtesy staff membership* in accordance with its remaining valid bylaws as if he had met all basic requirements for such admission.
>
> With regard to the suggestion that The Medical Society of New Jersey appear *amicus curiae* in the Appellate Court, it is my recommendation that the Society not oblige for the following reasons:
>
> (1) We fought and lost the doctors' battle in the Falcone case, and that was, and is, our main interest.
> (2) Our position would be difficult in view of the action of the Judicial Council concerning the voluntary professional association of M.D.'s with Osteopaths.

(3) The New Jersey Hospital Association has engaged to undertake the appeal as proper to its interests.

Practical Nurses in Major Medical Expense Program . . . Adopted the recommendation of the Committee on Medical Defense and Insurance that the services of practical nurses not be included under the Major Medical Insurance policy for the following reasons:

1) While certain persons are ready and willing to pay the premium for very comprehensive coverage, regardless of cost, a sound insurance program is not a matter of premium alone.
2) Underwriters have repeatedly stated that since there are just too few justifiable instances where a professional nurse is not available and a practical nurse is brought into the case, the company should not extend the nurse coverage to include practical nurse service expense.
3) If nurse coverage was extended to include practical nurse service costs, it would require at least a minimum increase of 25 per cent in the present premium rates.
4) Major medical policies usually exclude nursing homes and practical nurses because of lack of standard accreditation and difficulty of establishing care as medical rather than purely custodial or home-making.

Allocation of Losses in Professional Liability Program . . . Adopted the recommendation of the Committee on Medical Defense and Insurance that—where a physician is a member of one component society and practices in a different county—the allocation of losses and premium should be charged against component society in which the physician holds membership, on the basis that the component society vouches for him when it elects him to membership, and discipline of that member becomes the component society's responsibility.

Accidental Death and Dismemberment Program . . . Adopted the recommendation of the Committee on Medical Defense and Insurance that Nationwide Mutual Insurance Company's proposal (through E. & W. Blanksteen Agency) for accidental death and dismemberment insurance be endorsed as an additional insurance coverage for members of MSNJ.

Members may apply for self or for self and spouse; and choose the amount of insurance—$25,000 to $200,000. Coverage for spouse may not exceed 50 per cent of that of the member; it may be less than 50 per cent but not less than the minimum unit of $25,000. Member-physicians having accident and health insurance (basic, additional, and/or extended coverage) and the accidental death and dismemberment insurance will receive payment under both policies in case of an accident. The policy provides these accident benefits:

1) Accidental Death—The Principal Sum for loss of life.
2) Dismemberment—The Principal Sum for loss of both hands, or both feet, or one hand and one foot; one-half the Principal Sum for loss of one hand or one foot; one-fourth the Principal Sum for loss of thumb or index finger of one hand.
3) Loss of sight—The Principal Sum for loss of sight of both eyes, or one hand or one foot and sight of one eye; one-half the Principal Sum for loss of sight of one eye.
4) Total Disability—(Member only)—One percent of the Principal Sum per month for total disability. Payments begin with 13th month of continuous total disability and continue until full Principal Sum has been paid (or until prior termination of disability or death).
5) Exposure—Losses or total disability are covered as a result of unavoidable exposure to the elements of nature as a result of an accident.
6) Disappearance—Accidental loss of life is presumed one year after disappearance, sinking, or destruction of conveyance in which the insured person was a passenger.

Personal and Professional Catastrophe Liability Insurance . . . Approved the recommendation of the Committee on Medical Defense and Insurance that there is not sufficient statewide interest to justify a statewide policy for personal and professional catastrophe liability insurance. The Committee could see no objection to members' taking out this insurance on an individual basis, however.

Membership Insurance Program's Pamphlet . . . Accepted the recommendation of the Committee on Medical Defense and Insurance to share with American Mutual and E. & W. Blanksteen the publication costs of 10,000 copies of a pamphlet describing the several insurance programs available to MSNJ members. The pamphlet will be made available to component societies this fall for distribution with their annual dues' bills and sent hereafter to new members.

Civil Defense Laws . . . Referred to the Editor of THE JOURNAL for consideration—in accordance with the Board's earlier authoriza-

tion for the preparation of an article to inform members of existing civil defense laws and their responsibility under them—an article by the Committee on Disaster Medical Services entitled "Excerpts From the Basic Civil Defense Law as It Affects the Doctor."

Disaster Medical Care . . . Adopted the recommendation of the Committee on Disaster Medical Services that its name be changed to conform with the AMA Committee on "Disaster Medical Care."

Membership Directory . . . Accepted the following recommendations from the Committee on *Membership Directory*:

1) That the *Directory* is a useful tool to the physician and that a poll of the membership concerning its desirability is not necessary.

2) That a survey of the other state medical societies be conducted to obtain information concerning the publication and distribution of their membership directories.

3 That a list of county medical society office addresses be included in the *Directory*.

4) That an alphabetical listing of MSNJ membership by county medical society membership, in addition to the alphabetical listing for the State, was not warranted because of the extra cost which it would entail.

5) That the listing of MSNJ officers not be included in the *Directory* in the future. Such a listing is incorrect after the first year following publication, since the *Directory* is currently published every two years.

6) That further publication of the Directory be postponed for at least one year or until such time as the New Jersey Bell Telephone Company completes its conversion to the numbered dial system throughout the State.

7) That a list of Honorary members be included in the *Directory*.

8) That Emeritus and Associate members be identified as such in future editions.

9) That the alphabetical list of hospitals be moved from the front to the rear of the *Directory* immediately preceding the community hospital listings.

1961-62 *Audit Review* . . . Adopted the following detailed report and recommendations of the Committee appointed by the Board to review the 1961-62 Audit Review:

1) THE JOURNAL—The financial transactions of THE JOURNAL were reviewed, and it was noted that this publication grossed a deficit of $29,000 last year—net operating deficit, $16,000, plus the salaries of the Editor and Assistant Editor, $13,000.

Recommendation: That the entire operation of THE JOURNAL be reviewed by the Publication Committee, a disinterested publisher, and representatives from the Board of Trustees, to consider: (a) the subscription rate; (b) advertising rates; (c) bids for printing; (d) membership subscription rate—either as a part of, or in addition to, the regular annual assessment.

2) *Medical Student Loan Fund*

(a) Requirement #3 governing the Fund states: "The maximum amount to be annually available to any borrower shall be $1,000, to be repaid in the same amounts in which the loan was made, with repayment to begin two years after the establishment of practice." The committee interprets this requirement to mean that $1,000 borrowed in any one year shall be repaid in quarter-annual installments of $250 in one year's time—not in quarter-annual installments of less than $250 over a period of years, which is the present practice of the committee.

Recommendation: That the Committee on Medical Student Loan Fund coordinate the repayment of loans and requirement #3—by amending one or the other.

(b) It was recommended to the committee by the auditors that the amount transferred to MSLF should be a grant or appropriation —not a loan—since both funds are under the control of the Board. Carrying the transfer as a loan sets it up as asset under the general fund. This inflates the general fund and does not truly represent liquid funds.

Recommendation: That the transfer of monies to MSLF be made by annual action, if need is indicated, and that such transfers be not on a loan basis but be definite contributions.

3) *Reserve Accounts*—The committee questioned the need for the several reserve accounts which are carried in the books. The auditor pointed out to the committee that the current practice complicates the accounting and leads to incorrect conclusions, especially the transferring of balances in reserve accounts to other special accounts. It was his suggestion that all unexpended balances of reserve accounts be transferred back to the general surplus account for reappropriation for a specific purpose as required. The accounting would then reflect the actual expenditures against the reserve for which it was created.

Recommendation: That a review by the Finance and Budget Committee be undertaken of the need for reserve accounts.

4) *House Accounts*—The committee noted that the current budget (1962-63) includes a new account for house renovations and replacements. Formerly such expenses were paid through a reserve account maintained by transfers from the surplus account.

Recommendation: That the House Restoration and Replacement Account be a separate fund maintained and used for no other purpose.

Recommended Procedures in Hospital Deaths . . . Agreed that the "Recommended Procedures in Hospital Deaths" as amended by the New Jersey State Funeral Directors' Association and the New Jersey Hospital Association be approved for use as a guide.

AMA Clinical Meeting . . . Designated Dr. Frank Hughes of Camden as the sixth delegate to the Los Angeles, California, AMA meeting—November 25-28—to serve for Dr. C. Blaisdell of Asbury Park, who cannot attend; authorized the attendance also of the President, President-Elect, Secretary, Executive Officer, and Dr. Joseph R. Jehl of Clifton as the official alternate-delegate.

AMPAC . . . Recommended that steps be taken to establish in New Jersey a state political action committee, and authorized the President to appoint a special committee to set up the mechanics for the establishment of a state AMPAC office.

The Basic Civil Defense Law

New Jersey has a statute called "An Act concerning civilian defense and disaster control." Our Society's Special Committee on Disaster Medical Care (J. R. Karel, M.D., Chairman) offers the following excerpts from this statute. Every member of our Society should realize the special responsibilities and obligations bestowed on him under Annex 18 of the National Health Plan.

The purpose of our State's basic civil defense law is to provide for the health, safety and welfare and to prescribe a course of conduct for the civilian population during such emergency and, by centralizing control of all civilian activities having to do with such emergency under the Governor, to give the Governor control over such resources of the State Government and of every political subdivision. Under this law, the Governor is authorized to use all resources of the State Government and of every subdivision of this state, whether of men, properties or instrumentalities and to commandeer any personal services and privately owned property necessary to avoid or protect against any emergency, subject to the future payment of the reasonable value of such services and privately owned property. An office of civilian defense director is created to whom the Governor was empowered to delegate any of the powers conferred by this act. This organization was to be established in every municipality and county with an advisory council to assist in supervising and coordinating civilian defense and disaster control activities.

To accomplish the objectives of this act, the Governor was empowered to make such orders and regulations as may be necessary to meet the problems presented by any emergency in a notice by proclamation. On March 10, 1955, this proclamation was issued by the Governor as follows:

PROCLAMATION

Whereas, disasters may occur at any time and are not limited to periods of international tension or war; and

Whereas, pre-disaster planning and training is essential in the reduction of the effects of disasters upon the citizens and their property; and

Whereas, disaster control is a continuing and long-term element of municipal, county, state and national defense; and the core of disaster control organization must be based upon professional and semi-professional services augmented by highly skilled volunteer agencies, organizations and citizens.

Now therefore, I, Robert B. Meyner, Governor of New Jersey, to provide further safeguards for the public security, health and welfare, and pursuant to the authority vested in me by the State Constitution and by the provisions of Chapter 251 of the Laws of 1952, as amended and supplemented, do hereby promulgate and proclaim, effective immediately, that the within New Jersey State Disaster Control Plan, including all requirements, orders, rules and regulations prescribed therein, be and hereby is in full force and effect.

I do further proclaim that the mayor or other chief executive of each municipality in the State and the Board of Chosen Freeholders of each county in the State is charged with the establishment and maintenance of prescribed disaster control organization and procedures set forth in the New Jersey State Disaster Control Plan.

I do further proclaim that the aforementioned New Jersey State Disaster Control Plan and the requirements, orders, and regulations set forth therein shall, according to their respective terms, be binding upon all political subdivisions, public agencies, public officials and employees and upon each and every person of the State.

Note that all such orders, rules and regulations *are binding upon every person within this State*. An officer of a municipality or county charged with duties pertaining to civil defense or disaster control planning performs his duties in accordance with the rules promulgated by the Governor.

A New Jersey Plan for Medical and Health Preparedness was promulgated on March 5, 1952. However, in view of past and recent developments, this plan is presently being revised and will be submitted to The Medical Society of New Jersey for approval.

NATIONAL HEALTH PLAN

It is important to note that in The National Plan for Civil Defense and Defense Mobilization, Annex 18 (the "National Health Plan") it is stated that *every physician, hospital administrator, dentist, sanitary engineer, pharmacist, registered nurse, or other individual possessing any of the essential health skills is responsible for taking an active part in civil defense and defense mobilization planning and training in his community.*

The American Medical Association in a House of Delegates resolution has pledged itself this way:

Physicians of our country, individually and in associated bodies, must assume the basic responsibility of preparing for and assuming the management of mass casualties during a grave national disaster.

This resolution of the American Medical Association clearly sets the direction for disaster planning among the constituent medical societies where action must be generated. In today's world, medical preparedness for the kinds of disaster which cannot be evaded or avoided presents a tremendous responsibility and obligation to the medical and allied professions.

Salmonellosis and Paratyphoid

The following communication is submitted for your guidance. It comes from our State Department of Health over the signatures of Dr. Elmer Shaffer, director of the Division of Laboratories and William J. Dougherty, M.D., M.P.H., director of the Division of Preventable Diseases.

During recent months a number of cases diagnosed as salmonellosis, paratyphoid and typhoid have been investigated. In many of these cases, diagnosis has rested solely upon elevated titers of Anti-O, -H, -Paratyphoid A, or -Paratyphoid B agglutinins with stool and blood cultures reported as negative. Frequently the diagnoses resulting from the reporting of these titers have not been compatible with the clinical history.

Cultural diagnosis in these cases is definitive, and is the method of choice. Cultural methods for the isolation of Salmonellae are readily available throughout this state, either at local laboratories or through the State Laboratories at Trenton. If repeated negative stool and blood cultures are obtained before therapy is begun, the diagnosis of Salmonellosis, Paratyphoid, or Typhoid is *not* justified.

Agglutinin titers are frequently not reproducible, and as they are often seen to rise and fall non-specifically, apparently due to cross-reactivity with non-Salmonella antigens, an elevated agglutinin titer is not of itself diagnostic of Salmonellosis.

Because of confusion regarding the interpretation of these titers, their nonspecificity and lack of reproducibility, the State Department of Health strongly recommends that this examination be abandoned, and that laboratories currently performing the tests for anti-O, anti-H, anti-Paratyphoid A and anti-Paratyphoid B agglutinins discontinue them for diagnostic purposes.

In many municipalities Widal tests are ordered for food-handlers. The obvious intent is to determine if any such persons are "Typhoid Carriers". Such tests reveal nothing that is useful. Stool cultures are the only reliable means of detecting such carriers.

County Society Reports • • •

Bergen

The regular Annual Installation Meeting of the *Bergen County Medical Society* was held on September 11 at the Knickerbocker Golf Club. President Wahrenberger introduced Dr. Louis Wegryn, President, and Mr. Richard I. Nevin, Executive Officer, of The Medical Society of New Jersey. Sixteen honored guests, including representatives of several county organizations, were also introduced.

The following were elected to membership: Dr. John B. Voskian, to *active by transfer* from Los Angeles County Medical Association; Dr. David McCullagh Mayer, to *Active from Courtesy*, from New York County; Doctors P. J. Dornich, Morton Fier, Edward D. Fram, Ross S. McConnell, and Arthur V. Pinsky, to *Courtesy;* Dr. Arthur W. Pindar, to *emeritus;* and Dr. Donald McLane, *leave of absence.*

Dr. Phoebe Hudson discussed the activities of the Special Committee on Polio Immunization, of which she is the chairman, and indicated that 71 communities were preparing to conduct mass programs.

President Wahrenberger introduced the new officers of the Society: Dr. John P. O'Connor, *Treasurer;* Dr. Charles P. Campbell, *Secretary;* Dr. Marshall F. Driggs, *Second Vice President;* Dr. William T. Roe, *First Vice President;* Dr. Richard P. Keating, *President-Elect.* He then presented the gavel to incoming President Samuel B. Reich.

Dr. Wahrenberger stated that he was leaving a legacy consisting of a number of programs which required continued attention and action. These included regional hospital planning, liaison with the Bergen County Bar Association, Visiting Homemaker Service, member indoctrination course, Future Physicians Club, legislation for the aged, Investment Committee recommendations, and the polio immunization program.

In accepting the gavel, Dr. Reich presented a dynamic inaugural message stressing the role of the individual physician in the practice of medicine, and the threat to individual initiative and responsibility by proposed government programs to control medical practice.

Helping to make this dinner meeting an outstanding success were the following honored guests: Dr. Irving Chrisman and Dr. Francis R. Meyers, Secretary and President of Passaic County Medical Society; Mr. Nelson R. Henson, Administrator of Englewood Hospital; Mr. Martin S. Ulan, Administrator, Hackensack Hospital; Dr. Harris K. Cohan, Administrator, Hasbrouck Heights Hospital; Mr. N. T. Verrastro, Administrator, Pascack Valley Hospital; Dr. George F. Worcester, Jr., President, Bergen County Dental Society; Mr. Angelo Gemignani, President, Bergen County Pharmaceutical Society; Senator Walter H. Jones, President, Bergen County Bar Association; Dr. Edward J. Morrison, President, Northern New Jersey Veterinary Medical Association, Inc.; Dr. Rufus Little, Administrator, Bergen Pines Hospital; Mr. Donald G. Borg and Mr. William A. Caldwell of *The Record;* Mr. Victor D. Banta, President, Bergen Community Blood Bank; Mr. Henry W. Holman, President, Bergen County T.B. and Health Association, Inc.; Mr. Edward F. Walsh, President, Bergen County Chapter of The National Foundation.

WILLIAM L. PALAZZO, M.D.

Reporter

Salem

On September 21, with the president, Dr. William Staub, in charge, the regular meeting of the *Salem County Medical Society* was held at Richman's in Sharptown.

The yearly diabetic detection chairman is to be Dr. I. Lipkin. Dr. Robert Cox will conduct the Salem County Eye Health Screening Clinic.

The president announced that the reference library at Ancora State Hospital is open to all society members. Dr. Harry Brunt, the Medical Director, is soliciting donations. The reporter was instructed by the president, after a vote by the members, to issue a press release stating that the society is deferring action on a countywide program of mass immunization with the Sabin vaccine until clarification is received of the potential danger to adults of Type III Sabin vaccine.

At the request of the Salem-Cumberland County Association for Retarded Children, the society voted in favor of Phenistixs for the detection of Phenylketonurin. Dr. Gilpatrick announced that costs in the local Guidance Center are 40 per cent up, but referrals from private physicians of children were down from the previous year. He wishes to have any complaints referred to him if that is the reason. Dr. Norton reported that there is controversy on hospital employment of physicians, for in-patient care of patients. These are private patients. Also, he stated that there is to be a change in the welfare patient's care wherein they will have to sign only one form for a month's visits. The patients would be allowed five visits per month for acute illness and two per month for chronic cases. Also, there is to be an increase in Salem County fees for welfare patients, office and home visits by $1.00 next year.

Dr. Boyer introduced the guest speaker, Dr. Harry Zinsser, cardiologist, from the University of Pennsylvania, who gave an informative talk on "The Current Status of Surgery in Rheumatic Heart Disease." He showed motion pictures of the different diagnostic findings *via* cardiac catherization.

JOHN T. DOOLEY, M.D.

Reporter

Union

Sabin oral polio vaccine was the subject of considerable discussion at the regular meeting of the *Union County Medical Society* on September 13 at the White Laboratories in Kenilworth. The meeting was convened by the president, Dr. Charles Boozan. A report was given by a special committee appointed in June 1962 to study the question of mass immunization with oral polio vaccine. Following thorough discussion, the members voted to proceed with such a program. The use of society monies to initiate the project was approved when it was shown that similar programs in other parts of the country had all become self-supporting.

Memorial resolutions noting the deaths of Dr. Carl G. Kapp, a recent past president of the society, and Dr. Louis Lang were adopted.

The following were elected to *active membership*: Drs. Erich V. Mueller, Summit; Angelos L. Paraskevas, Iselin; Grace L. Tarrant, Elizabeth. Drs. William P. Liebesman, Westfield and Edmund S. Rachlin, Plainfield, were accepted for full *membership by transfer* from Zumbro Valley Medical Society, Minnesota and the Medical Society of New York County, respectively. Drs. Lorraine L. Jones, Plainfield; David Kaufman, Elizabeth; and Paul A. Arts, Plainfield, were elected to *Associate Membership*, the last named, by transfer from Denver, Colorado.

GEORGE L. ERDMAN, M.D.

Reporter

Announcements • • •

TB Testing in Schools

The intradermal test is now the only acceptable technic for tuberculosis screening in New Jersey's public schools, according to current regulations of the State Department of Education. Under the new rules, students in grades 1, 5, 9, and 12 of public schools must be screened for the presence of active or communicable tuberculosis. These policies were adopted on recommendation of the Tuberculosis Council of New Jersey. Previously, the "Patch test" was acceptable, and a screening was mandatory only during the four years of high school.

X-rays will be given only to those students who react to an intradermal test.

Persons who work in cafeterias of public schools (even though employed by an outside agency) now must be screened annually for tuberculosis, along with all regular employees of boards of education.

Intradermal tests acceptable for purposes of this screening are the Mantoux, Heaf, Tine, and Sterneedle.

Diabetes Colloquium in Washington, D.C.

On Thursday, December 13, an all-day seminar on diabetes will be held at the Washington (D.C.) Hospital Center. Under auspices of the Diabetes Association of the District of Columbia, the program starts at 9:30 a.m. with a discussion of the emotional aspects of juvenile diabetes. Other features of the day are talks on diabetic neuropathy, microangiopathy, use of unmeasured diets, insulin resistance, oral hypoglycemic agents, iatrogenic diabetes, and insulin antagonists. For details, write to Dr. Adolph Friedman, 1712 N. W. Eye Street, Washington 6, D.C.

Seminar on Renal Pathology

The Annual Slide Seminar of the New Jersey Society of Pathologist (in cooperation with the New Jersey State Department of Health) will be held on December 1, 1962, at 2:00 p.m., at the Essex House, South Broad Street, Newark. The Moderator will be Dr. A. C. Allen, Director of Laboratories, Brooklyn Jewish Hospital. Dr. Allen is also Clinical Professor of Pathology, State University Medical School of New York. The subject is *Renal Diseases*. Slides for this occasion, prepared by the Bureau of Pathology of the New Jersey State Department of Health, are being mailed. All readers of this Journal are invited.

Do You Have an Exhibit?

The 197th Annual Meeting of The Medical Society of New Jersey will be held at Haddon Hall, Atlantic City, May 11 to 15, 1963. Applications for space in the Scientific Exhibits are accepted up to December 15, 1962. Notification of the committee's action will be made soon thereafter.

Forms may be obtained from the Executive Offices of the Society—telephone EXport 4-3154; mail: P.O. Box 904, Trenton 5, N. J.; or visit: 315 West State Street, Trenton.

Members are cordially invited to apply for space in the Scientific Exhibits at the 1963 annual meeting, and are urged to obtain, complete, and submit applications early.

New Surgery Professor

The joint appointment of Dr. Joseph J. Timmes as professor of surgery at Seton Hall College of Medicine and director of cardiopulmonary surgery at B. S. Pollak Hospital has been announced. Dr. Timmes will work under the direction of Dr. Kenneth Judy, chairman of surgery at Seton Hall and surgeon-in-chief at Pollak Hospital. Dr. Timmes, a former Navy physician, fills a vital professional post, giving a Hudson County institution an open-heart surgery capability for the first time.

"That Dr. Timmes accepted these dual positions illustrates how the cooperation of the medical school and Hudson County works for the benefit of the hospital and the school, and ultimately for the good of the patient," said Paul J. Hanley, superintendent of the Pollak Hospital.

A graduate of Fordham University and Georgetown University Medical School, the new professor is an M.Sc. from the University of Pennsylvania. His early medical experience was gained at naval hospitals in Brooklyn and Philadelphia, and since 1955 he has been chief of thoracic surgery at St. Albans Naval Hospital. In 1958 he was named overall chief of surgery at the same hospital.

A Book About Epileptics

The U.S. Department of Health, Education and Welfare announces a new and useful book for and about epileptics. It concerns vocational planning for epileptics. Entitled *Total Rehabilitation of Epileptics*, subtitled "Gateway to Employment," it is sold by the U.S. Government Printing Office* at $1.25 a copy.

The volume is in four parts: "Toward a Better Understanding," "The World of the Epileptic," "Evaluating the Epileptic and His Disorder," and "Rehabilitation Performance."

Contributors are experts representing medicine, rehabilitation, psychology, social work, and counseling. While designed primarily for people who work with epileptics, the book is valuable for friends of epileptics or parents of young people with epilepsy. It includes a table of anti-seizure drugs.

In his introduction, Dr. Wright says that: "As a result of public prejudice, even the label 'epilepsy' is a social and employment handicap. In such a climate it is understandable that the 'normal' epileptic keeps his condition secret. So epilepsy remains the major hush-hush disorder affecting large numbers of people."

*Washington 25, D.C.

Obituaries • • •

DR. CHARLES D. CROPSEY

Something of a record was achieved by Dr. Charles D. Cropsey—a physician who actually served the people of his community for more than 70 years; Dr. Cropsey was born in New York City in 1870, when Ulysses S. Grant was President of the United States. In 1892 he was graduated from the New York Medical College and was its last surviving alumnus. He was also the senior staff affiliate at the Flower Fifth Avenue Hospital and was a laureate of our Golden Merit Award back in 1957. A few months prior to winning that honor, Dr. Cropsey was hailed as "Man of the Year" by the Rutherford Chamber of Commerce. He was a general practitioner on the staff of Passaic General, Hackensack and St. Mary's Hospitals. Dr. Cropsey died on September 14 at the grand age of 92.

HENRY B. KESSLER

Dr. Henry B. Kessler, born in 1883 in Austria, died on September 11, 1962. He came to New Jersey in 1890, and received his M.D. at Long Island College Hospital in 1905. He was founder and chief of staff at Newark Maternity Hospital from 1916 to 1931, when it was merged with the Newark Beth Israel Hospital. There he was a chief of the obstetrics service until he retired from staff duties in 1948. Dr. Kessler did intensive graduate work in gynecology and obstetrics in New York City. He was an early Diplomate of the American Board of Obstetrics and Gynecology and was an FACS. He was one of the founders of the American College of Obstetrics and Gynecology.

DR. GABRIEL OBESTER

On September 16, at the untimely age of 58, Dr. Gabriel Obester, an Elizabeth urologist, died of a coronary attack. Born in Passaic in 1904, he received his M.D. at Loyola in 1931. Dr. Obester served a two-year residency in urology at the Jersey City Medical Center and then came to Elizabeth where he opened an office for private practice. He served two years in the medical corps of the United States Navy. He was active in the affairs of the Union County Medical Society, and was on the staff of both Alexian Brothers and St. Elizabeth's Hospitals. Dr. Obester was Elizabeth's police surgeon and also had had a long tour of duty as City Physician.

ROBERT F. RAPP

On September 19 Dr. Robert F. Rapp died at his home at the age of 72. A 1933 graduate of Hahnemann Medical College, Dr. Rapp was active in the affairs of the Camden County Medical Society. A general practitioner at first, he became increasingly interested in otolaryngology, and was attending otolaryngologist at the West Jersey Hospital in Camden for many years. Dr. Rapp was one of the pioneer members of the New Jersey Academy of Ophthalmology and Otolaryngology. He was also active in local Masonic affairs.

DR. EDWIN SEIDMAN

The piano that entertained at so many medical meetings, the amusing lyrics and music that diverted so many hospital functions will be heard no more. Edwin Seidman died on October 10 at his home in Newark, at the age of 66. After service in World War I, Edwin Seidman entered Columbia University's College of Physicians and Surgeons and received his M.D. there in 1922. After interning at New York Mt. Sinai he returned to Newark for general practice. Increasingly he devoted his time to genito-urinary surgery and eventually became a senior attending urologist at three hospitals in Newark. He taught at the medical school of the University of Pennsylvania. Dr. Seidman was an early diplomate of the American Board of Urology.

DR. CARROLL THOMSON

One of the most versatile of our fellow-members, Carroll Thomson, died suddenly on September 4. He was born in Philadelphia in 1890 and won his M.D. at the Detroit College of Medicine and Surgery in 1916. He came to New Jersey in 1923 to become associated with the Fair Oaks Hospital in Summit and eventually became clinical director of that psychiatric institution. In 1949 he left the hospital to go into the private practice of psychiatry in Morristown and swiftly won appointment to the psychiatric staff of All Souls Hospital there. Dr. Thomson was a well known amateur musician, a master of several instruments, and a composer of more than average skill and creativity. He was active in the New Jersey District Branch of the American Psychiatric Association and in the New Jersey Chapter of the American Academy of Religion and Mental Health.

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Irritation and Counterirritation. By Adolphe D. Jonas, M.D. New York, 1962. Vantage Press. Pp. 368. ($7.50)

Dr. Jonas characterizes his book as a "scientific excursion into theoretical medicine." It is a fascinating and intelligent attempt to develop a unified theory integrating all somatic and psychic phenomena. He aims at the pinnacle of psychosomatic conceptualization by eliminating the need for a fusion of these spheres and substituting an indivisible whole. He visualized an "autoamputative property of the nervous system." This places the central nervous system at the top of the biologic hierarchy. Living in a constant environment of potentially hostile and irritative impulses, the CNS enjoys the ultimate defensive capacity of ablating or amputating a lower area or a function which cannot prevent hypernoxious stimuli from reaching the central areas. "The chosen organ acts as a buffer for painful social stimuli with the avowed purpose of acting as a signal for the person to remove himself from the threatening life situation. In the absence of an appropriate defensive action the organ will be subjected to unceasing noxious stimulation to which it will respond with hypermobility or hypersecretion. In this fashion the buffering action can no longer take place and the organ, in turn, becomes a source of hyperirritation provoking the AAP with characteristic psychosomatic symptoms." The manifestations of the AAP then, whether through necrosis, dystrophy or other antibiologic pathways, become the symptom-complex of disease.

This thesis is embellished and amplified in scholarly and encyclopedic fashion. The theory, described on the book-jacket by his enthusiastic publishers as "revolutionary," has perhaps a more modest but none the less laudatory evolutional origin. Prince in 1928 wrote "electricity and energy are the modes in which the immaterial reality of the brain processes, i.e., the animal consciousness is apprehended . . . through the senses by another organism." Velikovsky in 1931 pointed out that in primitive stages the organism, having not yet developed specific sense organs, perceives stimuli immediately through nerve centers. He characterizes the hypnotic trance as a regression to this atavistic state—perception without sense organs. In 1919, Ritter's "The Unity of the Organism" advanced the main thesis that "the organism in its totality is as essential to an explanation of its elements as its elements are to an explanation of the organism." Cannon's concept of the adrenals activating the neuromuscular action system in preparation for fight or flight seems to be a pre-statement of the AAP. Irwin in 1930 commented "the only real unity is that of the organism and as long as its cells remain in continuity they are to be regarded, not as morphologic individuals, but as specialized centers of an action into which the living body resolves itself and by means of which the physiological division of labor is effected." Coghill in 1926 concluded that "the visceral and somatic systems are obviously differentiating under a common factor of controls which appears to be inherent in the nervous system."

The existence of these illustrious progenitors casts no shadow on the brilliance of their heir. The work of Adolphe Jonas represents a synthesis and refinement of many earlier concepts along the still primitive pathway to our understanding of biologic systems. We have virtually passed the stage of apologizing for psychosomatic man and appear to have substantially entered the era of explaining him.

SANFORD M. LEWIS, M.D.

The Cervix Uteri and Its Diseases. C. F. Fluhmann, M.D. Philadelphia, 1961, Saunders. Pp. 556, illus. ($14.00)

Highest praise is due this outstanding contribution to the obstetric and gynecologic literature. As Dr. Fluhmann states in the preface, the cervix uteri until recently has had little attention paid to its activities as a distinct functional organ. Recently, however, "Cervicology" has arrived as a specialty of its own within the field of obstetrics and gynecology. This volume provides a firm base of information for it.

The author presents comprehensively and in convincing manner his own work demonstrating the cervical anatomy of grooves and clefts formation rather than the classic concept of gland formation. His extensive use of lucid microscopic serial sections with accompanying outline tracings makes the text easy to follow, and the conclusive usage of "thick" prepared sections puts a three dimensional frosting on the cake. The subject of cervical cellular changes from typical benign histology through squamous prosoplasia (metaplasia) to malignant change is extensively covered through the difficult art of comprehensive conciseness, clarity, and readability.

The section on diagnostic procedures which covers all available technics with instructions on performance and attendant advantages and diffi-

culties will be found very helpful clinically. Cervical injuries and diseases are well covered in the following section. The author then moves into high gear with an exhaustive but easy-to-read discussion of carcinoma *in situ* and invasive carcinoma. This is presented without bias, and with a fair overall presentation and appraisal of various radiologic and surgical principles and technics directed toward the common objective of prevention, diagnosis, and treatment of this common malignancy.

The bibliography is extensive but selectively drawn upon. The reader will be delighted with the author's honest humor appearing throughout the book. This superlative monograph should be "must" reading for all clinicians dealing with the cervix and its function.

J. B. Skelton, M.D.

Medical Genetics,1958-1960. By Victor A. McCusick, M.D. St. Louis, 1961, C. V. Mosby Co. Pp. 534. ($14.50)

This is not a textbook of genetics and could not be a substitute for one. The impact of genetic factors in all fields of medicine is becoming increasingly clear, and Dr. McKusick's reviews point out the direction of investigations in each field. This book is easy to use. The index is cumulative, and the sections are organized so that they proceed from the general to the specific. New books, history, general genetics, human genetics, methods, cytogenetics in man, biochemical genetics and congenital malformations are discussed first. Then, by systems, the genetic aspects are discussed.

These reviews are much more than bibliographic listings. A critical appraisal of reports and contributions has been made, and major omissions have been avoided. Appropriate illustrations, graphs and figures accompany each section.

This book should be particularly useful to clinicians who find it difficult to keep up with genetic aspects of their own specialties, and to general and human geneticists who do not have ready access to the clinical literature. Probably its usefulness will be broader than this as the genetic implications in all phases of medicine become more widely understood.

Dr. McKusick reviews the work concerning the amino acid sequences of variant hemoglobins and the description of chromosomal aberrations as the basis of congenital abnormalities in man. These he considers to be the most consequential of all the reviewed works of 1958, 1959 and 1960.

It is to be hoped that this review of genetic literature may be continued yearly. The reviews constitute a fascinating adjunct to the libraries of all who do clinical medicine and represent a valuable contribution to current literature.

Donald P. Beirne, M.D.

Problems in Surgery. By F. Glenn, M.D. and G. E. Wantz, Jr., M.D. St. Louis, 1961. Mosby. Pp. 512, illus. ($16.50)

The day of the "Compleat Surgeon" has passed. The press of technical advance and the massive progress in surgical knowledge in general make it impossible for a solitary surgeon to work effectively in all fields of surgery.

Problems in Surgery offers an opportunity for general and surgical specialists to appreciate activities in fields other than their own. This volume embraces thoracic, vascular, cardiac, abdominal, orthopedic, urologic, neurosurgical, plastic, endocrine and miscellaneous surgical problems. It is thus of value for all surgeons.

The format is attractive both in appearance and approach clinically. It is a record of many of the cases presented weekly at "Grand Rounds" of the Department of Surgery of The New York Hospital-Cornell Medical Center. The problem of care of individual patients is discussed and then additional comments and discussion are made, relating specifically to the case at hand and also the problem in general.

Drs. Glenn and Wantz have selected much interesting material. Most of it is spontaneous discussion taped at the "Rounds."

The book is well recommended for the analytic and thoughtful surgeon. The authors deserve special thanks for revealing examples of successful surgery and patient care and also failures and complications.

Robert K. Spiro, M.D.

Public Health for Reluctant Communities. By James G. Roney, Jr., M.D. River Edge, N.J., 1961, River Edge Printing Co. Pp. 71. (No price stated)

When the editor asked me to review a book called *Public Health for Reluctant Communities*, I thought: "This sounds like some reluctant communities are about to get a severe lecture." Soon a paper-back brochure arrived with the title on the cover. "Reluctant" was in red. I was sure I was about to read the work of an angry pamphleteer.

It is no such thing. The tone is moderate, and there is occasional humor. Many aspects of public health work are packed into 70 pages. It is the kind of thing that can be done only by a man who knows his subject well.

The author touches upon such subjects as the changes brought by the rise of civilized living, the personnel in health departments, the responsibility of citizens, welfare services, and volunteer organizations.

The author states that the book is for lay people whom he defines as all those who are "not trained and/or not experienced in public health." Actually, anyone, with or without training or experience, could read this book profitably.

David Biber, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

NOVEMBER, 1962 • VOL. XXXV, NO. 9

UNTREATED INACTIVE PULMONARY TUBERCULOSIS

Because of the risk of reactivation of inactive tuberculosis, followup of persons with inactive disease should receive high priority in programs to find active cases, according to findings in a study conducted in Muscogee County, Georgia.

Information gathered by the Muscogee County (Georgia) Tuberculosis Study was used to estimate the prognosis of untreated inactive pulmonary tuberculosis.

The population from which the cases of untreated inactive pulmonary tuberculosis were drawn comprises all persons between 15 and 64 years of age who were first reported between January 1, 1946, and January 1, 1956, to the Muscogee County Tuberculosis Study as having definite or suspected tuberculosis. They had never been advised to be hospitalized for tuberculosis and were still registered as having suspected or definite pulmonary tuberculosis two years after the first report.

STUDY POPULATION

A total of 1,327 persons were included in the study. Almost 70 per cent of the cases were in whites and 30 per cent in Negroes. However, the rate was slightly higher among Negroes since considerably fewer Negroes than whites resided in the county. A much higher proportion of Negroes than whites was classified as having advanced disease, 44 per cent as contrasted with 23 per cent. For both races, the proportion of advanced tuberculosis was larger in the 15 to 44 age group than in the 45 to 64.

More than three-fifths of the cases were found among presumably healthy groups. Only a few were identified because they had been in contact with a case of active tuberculosis. A third of the total group was classified as symptomatic.

No single criterion for defining active tuberculosis seemed adequate. Even the finding of acid-fast bacilli with the cultural characteristics of *Mycobacterium tuberculosis* was not satisfactory since acid-fast bacilli have been isolated with considerable frequency from certain healthy population groups. The use of roentgenographic change also seemed inadequate as the only criterion.

ACTIVITY DEFINED

The most appropriate weighting of the various diagnostic factors appeared to be defining the onset of significantly active disease as the time when hospital treatment was first recommended, this being recognition of a significant adverse change in a patient's condition.

Inactive tuberculosis was defined as the absence of significantly active tuberculosis for at least two years after the individual was reported to the study as a tuberculosis case or suspect. Of the 1,327 persons, 314 were thought to have active tuberculosis. Five persons without evidence of active disease are known to have died during the two-year period. The remaining 1,008 comprise the inactive cases for this analysis.

GEORGE W. COMSTOCK, M.D., *Public Health Reports*, June, 1962.

The analysis includes observations on all persons in the study population through June 30, 1960, with the total period of observation ranging from four and a half to 14 and a half years. Because two years had to elapse before a person could be classified as having inactive disease, the potential range of observation for cases of inactive tuberculosis was two and a half to 12 and a half years.

Of the 68 persons for whom hospital treatment was recommended, 60 had positive bacteriologic and roentgenographic evidence of active tuberculosis. Of the 940 persons for whom hospital treatment was never recommended, two had both bacteriological or roentgenographic evidence of active disease.

RISK FACTORS

Of the 1,008 persons who had not developed active disease in the first two years, 68 were considered to have developed active disease during the next seven years, 53 of them during the next five years. The risk was greater for Negroes than for whites, for younger than for older persons, and for those with advanced disease than for those with minimal or suspected disease initially. The risk for males was not significantly different from that for females.

For Negroes with advanced inactive tuberculosis, the risk of developing active tuberculosis within a five-year period was somewhat greater than 30 per cent, and for whites approximately 10 per cent. For persons with minimal or suspected disease who were under the age of 45 years, the risk of reactivation was approximately 15 per cent for Negroes and 5 per cent for whites. For older persons with minimal or suspected disease, the rate approximated 4 per cent for Negroes and 2 per cent for whites.

The risk of reactivation for inactive cases was greater shortly after the subjects were placed in that category, and tended to diminish thereafter. Among persons with little evidence of disease initially, the risk of reactivation appeared to approach zero for whites and older Negroes after about eight years of observation. For younger Negroes with minimal or suspected tuberculosis initially, the risk of reactivation remained high throughout the study.

This study shows that followup of persons with inactive disease should receive high priority as a procedure for finding active tuberculosis. Few, if any, other groups in this country will experience a comparable incidence of active disease.

LONG SUPERVISION NEEDED

Although the risk of reactivation may decrease with the passage of time after initial report, it remains sufficiently great to warrant supervision for at least 10 years after a suspected tuberculous lesion is recognized.

How frequently periodic examinations should be made is a much more difficult question. The answer depends to a considerable extent on whether reactivations tend to be acute and symptomatic, or chronic and insidious. It is not possible to be certain about this unless persons with inactive tuberculosis are examined frequently over a long period of time, and this was not done in the present study. However, many reactivations seemed to have occurred acutely, often causing the patient to seek medical advice before the next scheduled examination. One might suggest routine examinations every three to six months for the first few years of observation, with annual examinations thereafter. Prolonged followup with infrequent examinations may well be more valuable as a reminder that prompt medical evaluation should be sought when respiratory symptoms occur than as a direct measure to detect asymptomatic reactivation.

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1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.; Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

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1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

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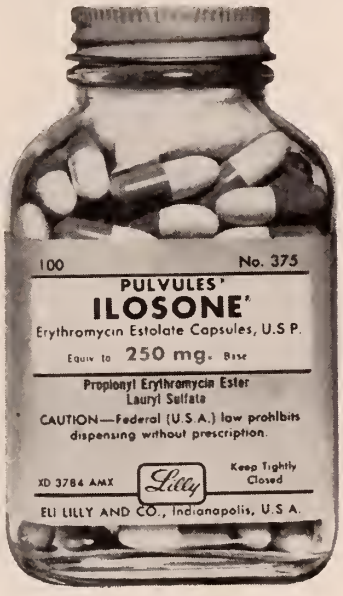
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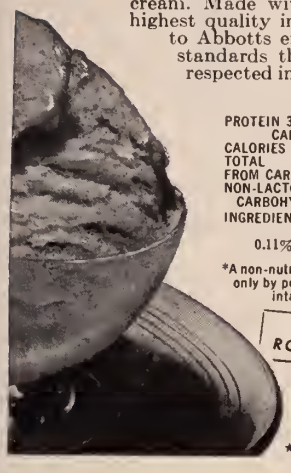
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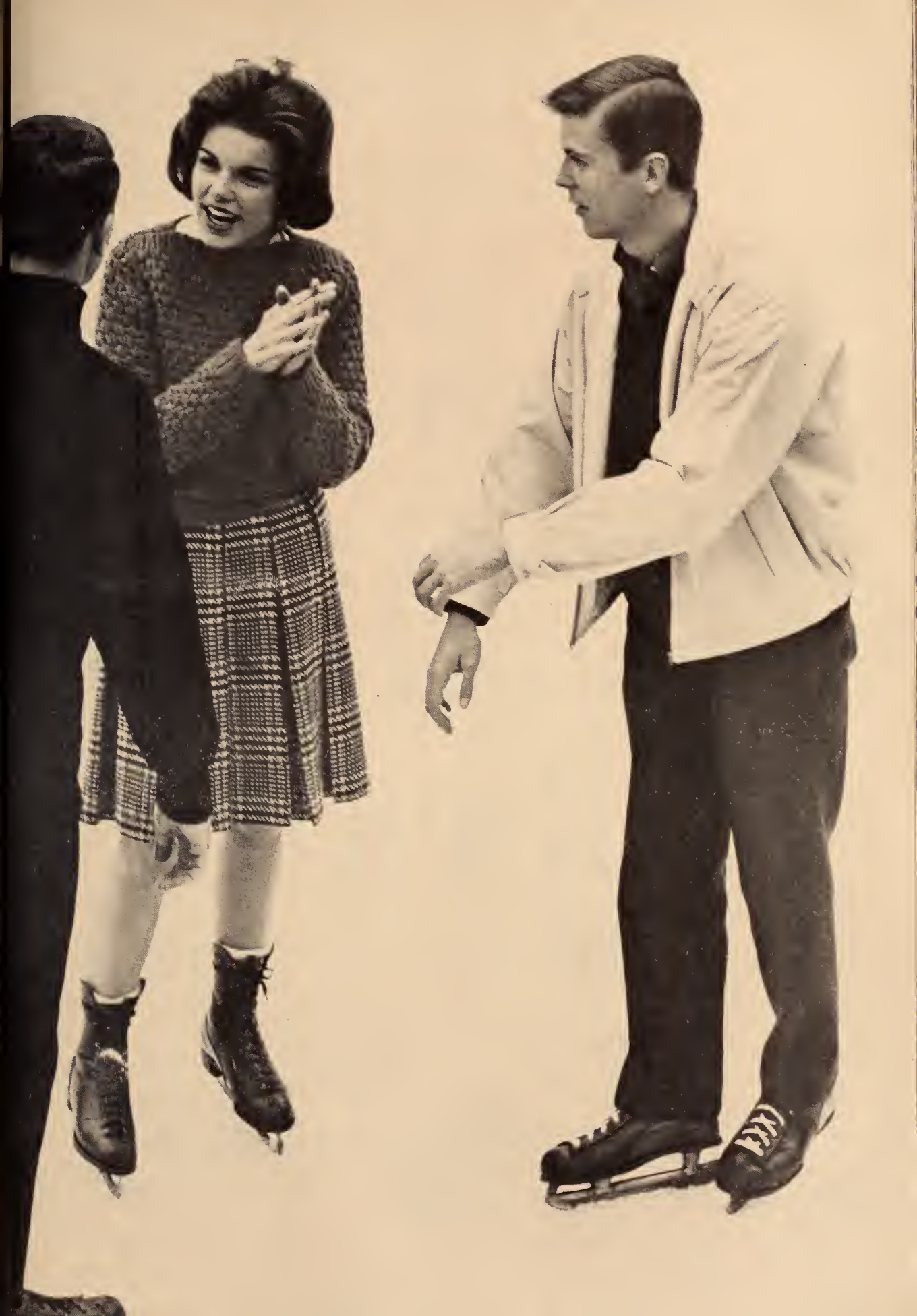
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OF

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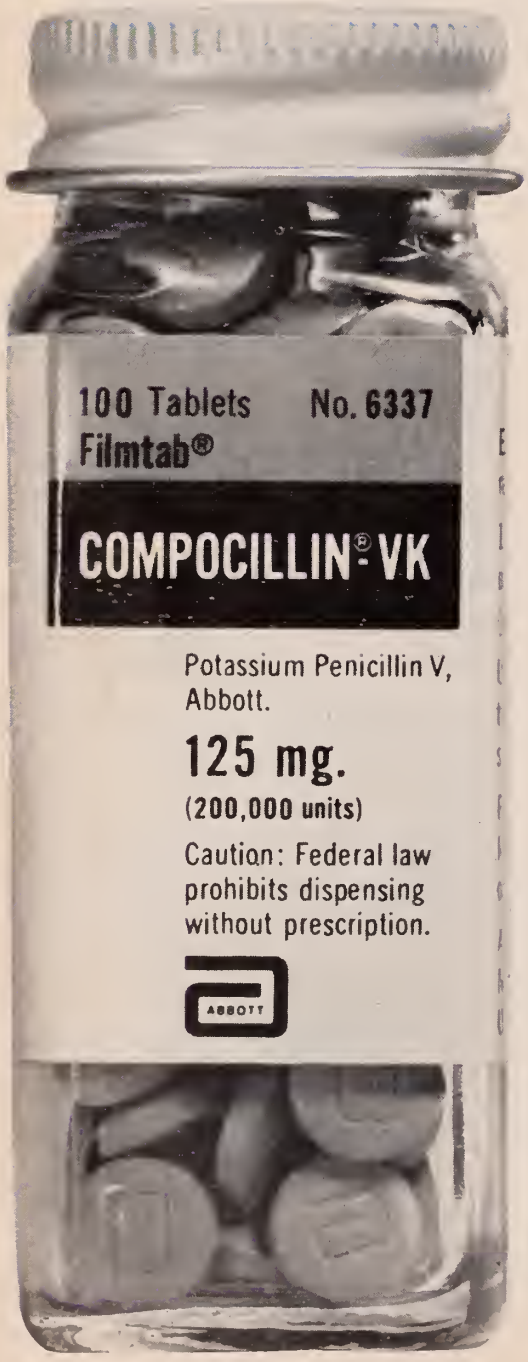
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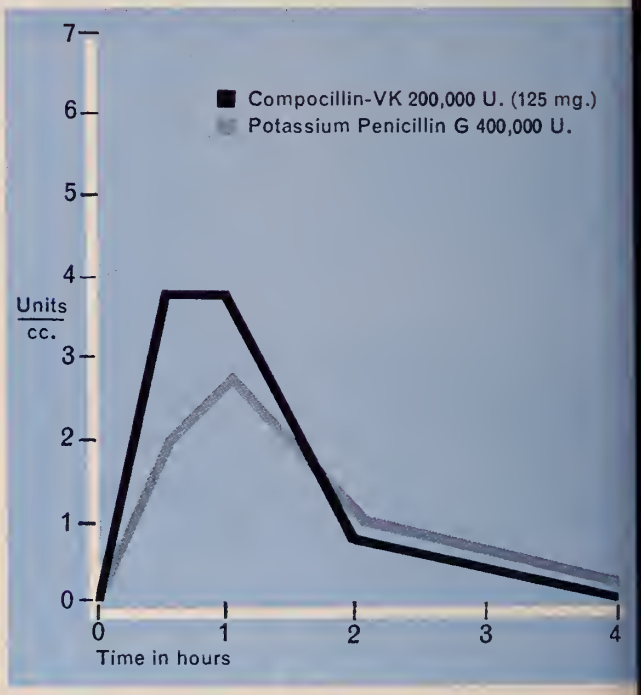
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Compocillin-VK—the original potassium penicillin V • In Filmtab (125 and 250 mg.) and cherry-flavored Granules for Oral Suspension

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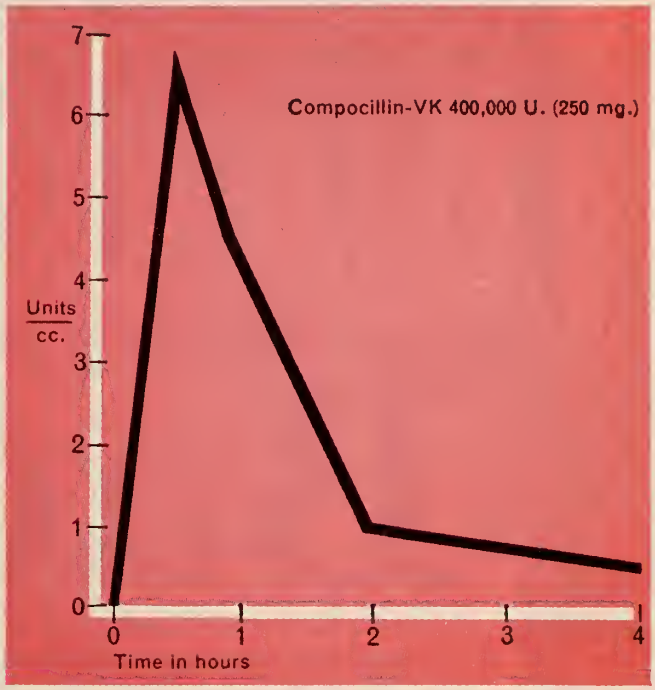
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*Chart data from two separate studies completed by the Microbiologic and Medical Departments of Abbott Laboratories.

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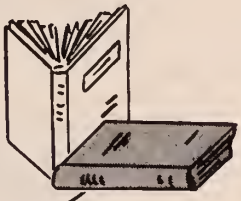
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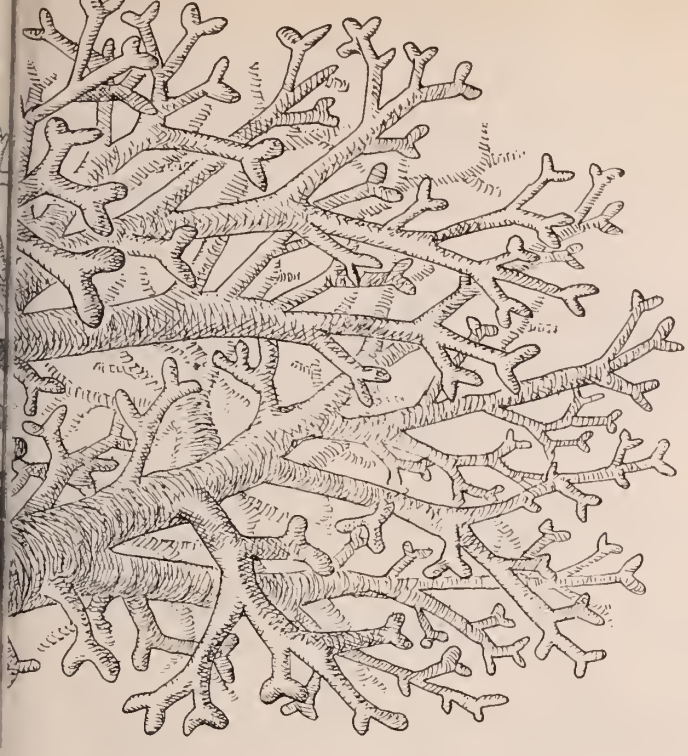
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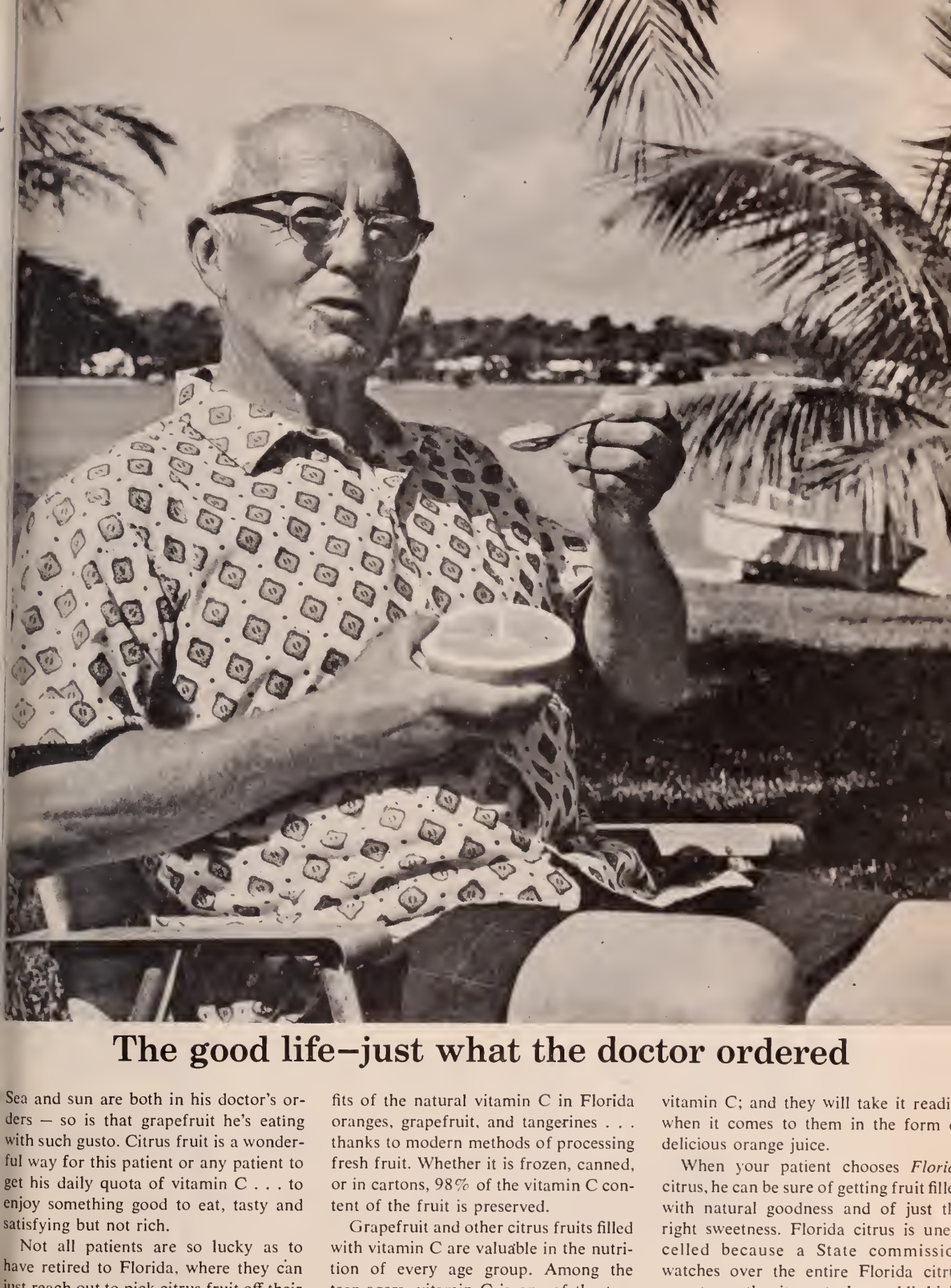
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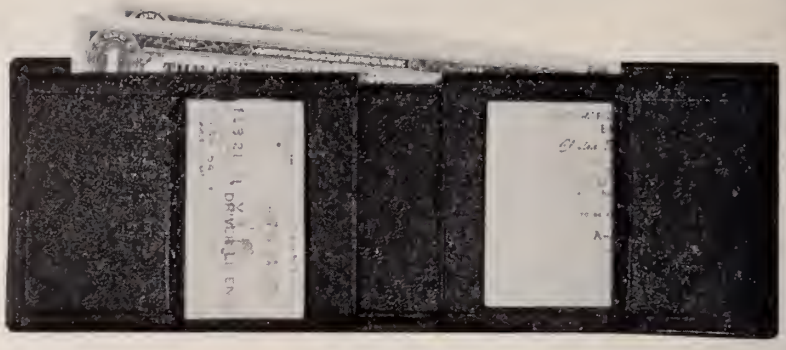
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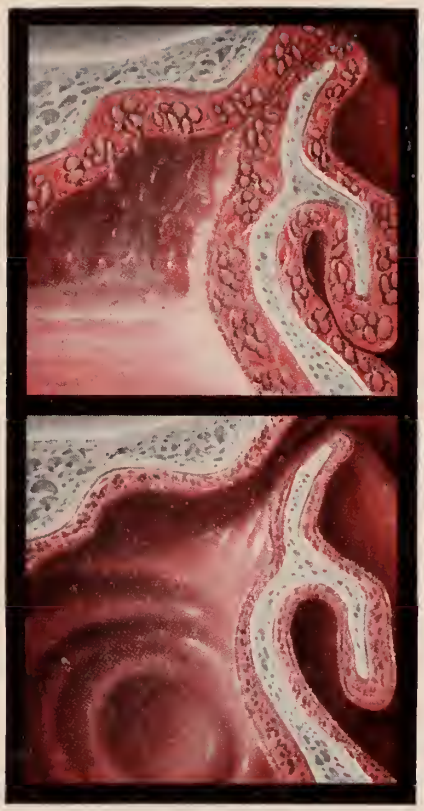
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.



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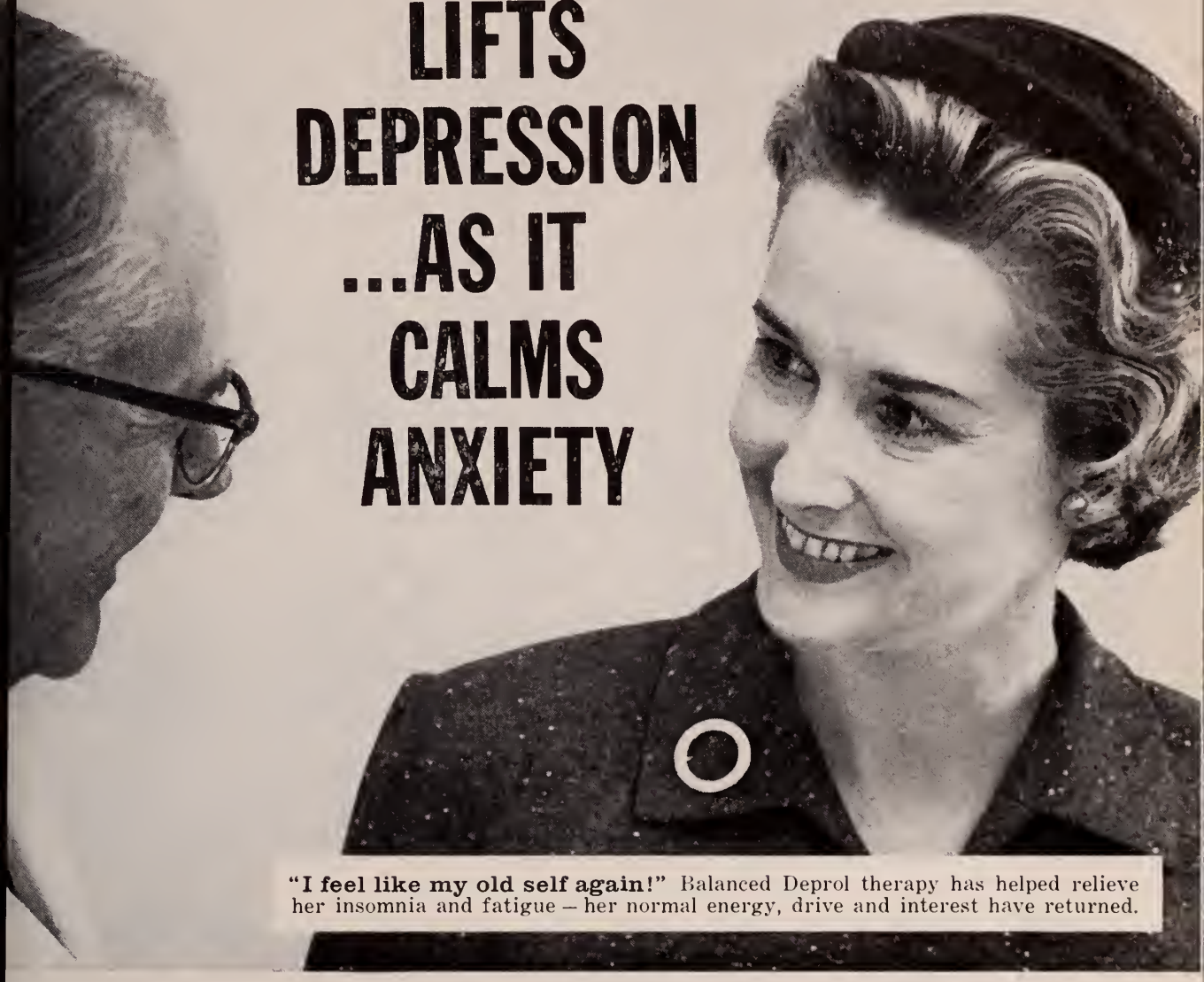
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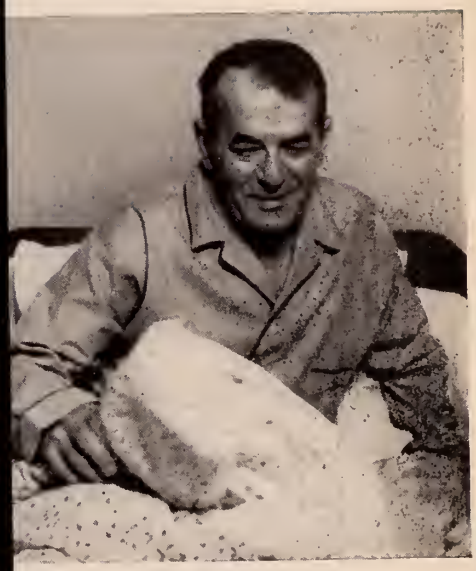


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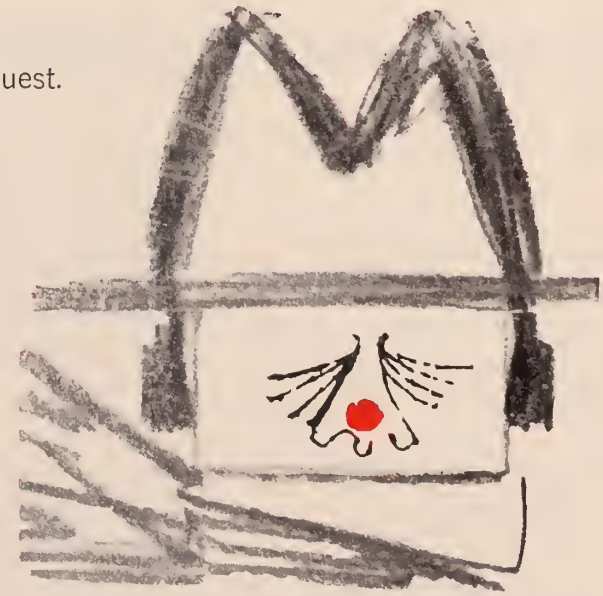
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1 Ford, R. A., and Blanchard, K Journal Lancet 78 185, 1958.

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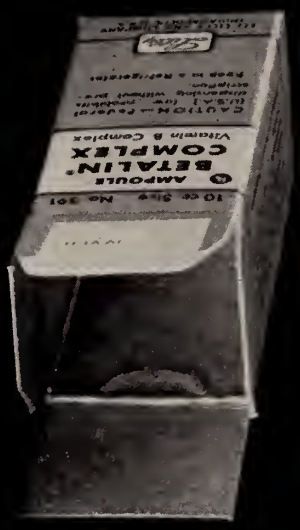
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Editorials • • •

Technology and Medical Art

In Britain a surgeon is called "Mister;" an internist is "Doctor." Our British colleagues conceive of the surgeon as a craftsman in a narrow technical field. They see the internist (rightly or wrongly) as a philosopher in medicine with a broad field of interest.

Galdston† has pointed out that many specialists depend on instruments and instrumentation. Without the ophthalmoscope, there would be little ophthalmology. Obviously the specialty of radiology was made possible by the development of x-ray equipment. Any policeman can deliver a baby but you have to have a specialized knowledge of obstetrics to use forceps. It was the development of forceps and of obstetrical maneuvers and of obstetrical surgery which made possible the specialty of obstetrics. There would be little to the specialized practice of cardiology if the cardiologist did not have available a variety of diagnostic instruments ranging from the x-ray to the stethoscope, the sphygmomanometer and the electrocardiograph.

The ideal internist has little need of instruments as he depends on his overall clinical judgment and his more sensitive understanding of the total human being. If an internist gets to the point of depending entirely on equipment, instruments and laboratory results, we think him the smaller man because of that.

Galdston† suggests that medicine consists of two components—*gnosis* and *technc*. *Gnosis* is the Greek for "knowledge" as seen, for example, in words like agnostic or gnomen. *Technc* is the Greek word for artifice as seen in words like "technic." Now most of the recent advances in medicine have been in the field of technic. This has been due to the phenomenal growth of technologic sciences.

Until recently, emphasis on medical care was on the handling of acute conditions. This was true in surgery, and is also noted in such practices as the treatment of pain or the man-

†Galdston, Iago: May 16, 1959 *Journal* of the American Medical Association.

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agement of heart attacks. Chronic conditions have been the concern of physicians only recently since these represent *health maintenance* rather than curative problems. The pediatrician, who is interested in healthy children and in keeping them healthy, would be an example. Medical schools today put emphasis on technical procedures and on instrumentation as, indeed, they must because medical school faculties are composed almost 100 per cent of specialists. It is hard to imagine a medical school which would find a major place for a general practitioner except as a token. Subjects in medical school are taught in separate compartments with occasional common or overlapping material. These infrequent joint teachings have little impact on the shaping of the medical students. Indeed, there is actually some feeling that concern with the broader philosophical or psychobiologic aspects of medicine is something to be embarrassed about.

Even the general practitioner tends to broaden himself by developing more technics. For instance, a general practitioner may take a course in electrocardiography and then read his own electrocardiograms. The next year, he learns how to operate basal metabolism equipment and installs one in his office. He, thus, would be able to give his patients a good grade of service as he could do metabolic tests or electrocardiograms when needed. If he is ambitious and alert, he could, each year, take a course in some other field of medicine. He can learn how to use obstetrical forceps and how to give anesthesia. Such a general practitioner, after ten or fifteen years, might feel that he comes very close to the ideal doctor.

Unfortunately, all he has done has been to thread together a number of technics like so many beads on a string. He has not actually advanced his knowledge of the total human being. Each of the specialties he has studied represented a narrowing rather than a broadening experience.

Even in teamwork, it often happens that the team does not function *as a unit* in spite of its high aims. Instead, it becomes a compromise between a number of individual specialists. We have been in meetings, for example, where the ophthalmologist shrugs his shoulders and says: "Well, all I can tell you—from the ophthalmologic viewpoint—this man is normal." Then the ophthalmologist becomes bored and doodles on his pad rather than listen to what the orthopedist or psychiatrist has to say. He might be dying of a brain tumor or a decompensated heart; the ophthalmologist says: "Ophthalmologically speaking, he is normal." (We are not picking on ophthalmologists. All specialists are sometimes guilty of this.)

One of the much-talked about aspects of medical training is the lack of liberal education in the humanities in the undergraduate colleges. While many medical schools assert that they are looking for a well-rounded premedical student and not necessarily for a scientific specialist, the actions of the Admissions Committees belie this protestation. The Admissions Committee is more likely to accept the student with good marks in chemistry or biology than to accept one who has majored in history or philosophy. The deans of the medical schools *say* they want a well-rounded citizen rather than an over-trained scientist. Unfortunately, this point of view does not prevail during the meetings of the Admissions Committee.

Technology is wonderful. It has saved lives and brought us awesome medical advances. But we need something more. The good physician needs *gnomen* as well as *techne;* breadth as well as depth; philosophy as well as science. Medicine cannot become anti-intellectual.

The Commonest Disease

What is the commonest disease seen by private practitioners? Right the first time: physicians in private practice see more patients suffering from respiratory diseases than from any other single group of ailments. Respiratory diseases often predispose to or co-exist with tuberculosis. Hence the voluntary tuberculosis associations are increasingly (and wisely) concerning themselves with *all* respiratory diseases. This winter and spring they will conduct a nationwide publicity effort to teach people that "if you have chronic cough or shortness of breath, don't take chances with respiratory disease—see your doctor."

This educational crusade may be one of the greatest services of the voluntary tuberculosis associations since their "Don't spit" campaigns of an earlier age, and since they taught a disbelieving world that tuberculosis is not inherited.

The Tuberculosis and Health Association is not intended to be medical or service oriented; its role is primarily educational. As health educator, the TB Association is outstanding. Christmas Seals support an educational program basic to our own fight against tuberculosis and other respiratory diseases.

The Doctrine of "Knowing Consent"

One of the harassments to which some doctors are now subjected is a liability action based on the theory that the physician acted without the patient's consent. True, the patient signed an authorization—but, so the theory goes, he would not have consented if he realized the possible untoward effects of the procedure. Thus, the consent was based on ignorance, and was not a "knowing consent." This thesis has a certain plausibility. One patient, for example, signed authorization for a mammectomy but said orally: "Whatever you do, doctor, don't remove my breast." The word on the consent form was "mammectomy" which the patient did not understand. Here the operation was without "knowing consent," since the doctor admitted he heard the oral plea, and had replied soothingly: "There, there, don't worry; everything will be all right." And if you remove the gasserian ganglion, the patient ought to be told in advance that he never again will feel any sensation from his face, so that he can make a knowing choice between the pains and the permanent anesthesia.

But the doctrine of "knowing consent" is not that simple. It can, indeed, be mischievous. Should you, before each tonsillectomy, tell the anxious parents of all the dreadful complications that might—just once-in-a-million, *might* happen? Would any man have his hernia repaired if the surgeon recited a list of possible untoward results? Would anyone take an aspirin tablet if the physician said that once in a million times this causes gastric hemorrhage?

To avoid liability claims based on this doctrine, the doctor has to stick only to procedures that have *never* produced complications; to drugs that have never caused an untoward effect. A medicine where everyone plays it safe is a stagnant medicine. This innocent sounding, reasonable sounding doctrine may hurt our patients.

RICHARD E. GORDON, M.D., PH.D
MARCIA G. SINGER, M.A.[2]
KATHERINE K. GORDON, M.A.[2]

Englewood

The Stress of Obtaining a Higher Education*

The pressure to achieve a higher education may also be an emotional stress: an obvious conclusion but one seldom as well documented as in this study.

INCREASING numbers of people throughout the world are seeking to rise above their less-privileged origins. Many seek to do so by gaining a higher education. Only four per cent of the American high school graduates in 1900 went to college. But in 1961, enrollment of full and part-time students in colleges and universities [19] reached the all-time high of 3.9 million—7.8 per cent above the 3.6 million of 1960. The number of students enrolled for the first time rose to 1,026,000, up 10.4 per cent over 1960. Forty-three per cent of the 1961 high school graduating class followed this course. Thus, four per cent sky-rocketted to 43 per cent!

Efforts of the "educational risers" are often associated with changes in values and new life situations for which they were unprepared. Resulting stress [1] may be associated with emotional and other medical disorders.

Christenson and Hinkle,[2] in their study of executives who climbed "up from the ranks," called attention to the differences in the amount of illness among young male executives of "similar" heredity and in the same working environment. Those who had risen from the ranks to attain managerial positions were found significantly *more likely* to suffer from physical and emotional disorders, both chronic and new. They actually suffered a higher risk of death than those who were college graduates before being hired by the company. The college graduate group were significantly more likely to be fourth (or later) generation Americans. They tended to have middle and upper class, better-incomed parents who were at least high school graduates. They lived in better homes.

The "up-from-the-ranks" group were more usually sons and grandsons of grammar school-educated immigrants. This socially mobile, climbing group were more likely to have come from homes with disturbed family relations. The rising group had more dependents, and more domestic and financial difficulties. They were taking vocational or night college training, and were involved in major "do-it-yourself" home activities. The college group were significantly more involved in civic activities.

The present writers [3 to 7] have made similar observations about the greater tendency to physical and emotional illness of many "upwardly climbing socially mobile" middle class

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*This study has been supported in part by a grant from the New Jersey State Department of Institutions and Agencies.

groups, compared to those who were born to the middle and upper classes. Some of the stresses the economically, socially and educationally mobile encountered, and possible means of reducing them were outlined in *The Split-Level Trap*.[5]

A major battle in the world-wide competitive struggle to advance is being fought behind the walls of ivy. Several questions may be asked. (1) Is this great competition to obtain education related to the development of large numbers of emotional casualties? (2) Are the newcomers to education, the upward climbers, especially likely to succumb to education-related emotional difficulties? (3) Are emotional disorders that are related to educational problems more, or less serious than other emotional disorders unassociated with education in patients of comparable ages?

This report will attempt to find some answers to these three questions.

METHOD

This study contains two independent but related sections. In the first section, the records of a group of 249 private psychiatric outpatients were analyzed for evidence of relationships between educational problems and the development of emotional illness.

The patients were single adolescents and young adults of both sexes from a New York Metropolitan area suburb who sought psychiatric aid during four time periods—1953-1955; 1956-1957; 1958-1959; and 1960-1961. The patients were grouped into six classifications: one each for males, and for females, in three age categories, aged 13 to 17; 18 to 24; and 25 to 30. Father's occupation, the patient's religion, and patient's parental birthplace provided indicants of economic and social position and background. A modified Hollingshead scale[6] was used in categorizing social class.

The Catholic patients were drawn mostly from the "lower middle class"; predominantly from the clerical and skilled worker groups. Jews were more likely to stem from upper middle class backgrounds. Many Jewish students had parents who were managers and professional people. Both Jews and Catholics tended to be the children or grandchildren of immigrants. The Protestants came predominantly from the mid-middle class, often with families in white collar occupations or small businesses. (See Table 1). They were more likely to be fourth or longer generation Americans than were patients of other faiths.

In the second section of the study, data from a group of 52 male "special" students with the poorest high school records on admission to Wagner College were compared with information from 55 male regular freshmen from the same institutions with average or better admission grades. Personal history questionnaires of both groups were compared on admission and after attendance of a semester at the College. Comparison of personal and social history items between those who had done well, those who fared poorly, and average students, produced a series of items which discriminated between more and less successful students.

TABLE 1.

COMPARISON OF RELIGION AND ECOMOMIC AND SOCIAL STATUS OF 85 SINGLE MALE ADULT PSYCHIATRIC OUTPATIENTS, AGED 18 TO 30*

		Upper Middle Class	Mid-Middle Class	Lower Middle Class	Laboring Class	Total
		%	%	%	%	%
Catholic	46	0	30	57	13	100
Protestant	24	25	50	21	4	100
Jewish	15	53	40	7	0	100
	85					

Most of the Protestant students were Lutherans of German or Scandinavian descent. They were more likely than Catholics and Jews to come from intellectually motivated families who had resided in America four or more generations. The Catholics more usually were rising above their parents' social or econ-

*Jewish patients tended to come from the higher economic and social classes and Catholics from the lower, with Protestants intermediate in status.

TABLE 2.

PERCENTAGES OF SINGLE PERSONS WITH EDUCATIONAL PROBLEMS SEEKING OUT-PATIENT PSYCHIATRIC HELP

Time Period		1953-55			1956-57			1958-59			1960-61		
		* I	II	III	I	II	III	I	II	III	I	II	III
Males	N		32			35			41			19	
Aged 13 to 24	%	34	31	34	54	14	32	56	29	15	74	21	5
Females	N		22			14			25			14	
Aged 13 to 24	%	41	14	45	14	21	64	40	12	48	21	29	50
Males & Females	N		14			20			7			6	
Aged 25 to 30	%	0	14	86	0	30	70	0	0	100	33	50	17

omic position. They and the Jews were also second or third generation Americans. In general, the college students were similar in background to the patient group.

The significance of any differences between groups was determined by means of chi-square. The Contingency Coefficient (C) was used as a measure of correlation.

It is important not to confuse specific items with the factors they are used to measure. An item itself, such as the student's religious affiliation or his participation in intellectual activities, cannot tell us a great deal about values and interests. Examination of significant relationships between items may suggest useful inferences, but not final conclusions.

RESULTS

THE *study of relationships between educational problems and need for psychiatric care* showed that increasingly larger proportions of teen-aged boys and single men under the age of 25 required out-patient psychiatric assistance for emotional disorders complicated by educational problems in each time segment from 1953 to the present. The ratio of those whose difficulties were related to primary educational problems rose from 35 per cent of male subjects in 1953 to 1955 to 74 per cent of subjects in 1960 and 1961. Almost all young single male psychiatric patients presented problems related to education in the latest period. There were no corresponding rising percentages of educational problems among young single female psychiatric out-patients, nor among the slightly older group of single men and women aged 25-30. (See Table 2). Women and older single adults are not striving as hard for higher education as are boys and young men.

Among teen-aged children, significantly larger numbers of Catholic boys and girls (the primary "educationally rising" group) came for psychiatric help in recent years, as compared to Protestants. (See Table 3). Catholic and Jewish men sought out-patient psychiatric assistance significantly more than women of their faiths. Increasingly, more single Jew-

TABLE 3.

CHILDREN AGED 13 TO 17 SEEKING OUT-PATIENT PSYCHIATRIC HELP**

Time Period	1953-57		1958-61	
Number	22	7	26	10
	Per Cent		Per Cent	
	Boys	Girls	Boys	Girls
Religion				
Catholic	23	43	38	80
Protestant	59	57	38	20
Jewish	18	0	24	0
	100	100	100	100

*I—Educational difficulties were described by the patient as the primary presenting problem. II—educational difficulties were mentioned as contributing to the present problem, but not as a primary factor. III—education was unrelated to the patients' problems.

Significantly larger ratios of teen-age boys and single young men under the age of 25 sought psychiatric help in each time period for emotional disorders associated primarily or secondarily with education. No similar trend appeared with young women and girls, nor with single men and women aged 25 to 30.

**Significantly larger proportions of Catholic, compared with Protestant, boys and girls sought outpatient psychiatric help in recent years. There were insufficient numbers of Jewish children from which to draw any significant conclusions.

ish young men obtained psychiatric help during this period, as compared to single Protestants. (See Table 4).

TABLE 4.

SINGLE ADULTS SEEKING OUT-PATIENT PSYCHIATRIC HELP*

Time Period	1953-55	1956-57	1958-59	1960-61
Males (18 to 30)				
Number	16	30	28	11
	Per Cent	Per Cent	Per Cent	Per Cent
Catholic	56	63	50	36
Protestant	38	27	26	18
Jewish	7	10	24	45
Females (18 to 30)				
Number	25	22	25	10
	Per Cent	Per Cent	Per Cent	Per Cent
Catholic	52	41	48	40
Protestant	36	41	48	40
Jewish	12	18	4	20

Educational problems were significantly related to the need for hospitalization of younger men, aged 18 to 24. Forty-one per cent of previously hospitalized young people aged 18 to 24, were men with primary educational complications; none of the hospitalized women had primary educational problems. Among older men and women (aged 25 to 30) who presented similar educational difficulties, 16 per cent were men and 8 per cent were women. (See Table 5).

TABLE 5.

EDUCATIONAL PROBLEMS AMONG PREVIOUSLY HOSPITALIZED SINGLE MEN AND WOMEN WHO LATER SOUGHT OUT-PATIENT PSYCHIATRIC HELP

Number	17				25		
	**I	II	III		I	II	III
Aged 18 to 24				Aged 25 to 30			
	Per Cent				Per Cent		
Males	41	23	0	Males	16	12	32
Females	0	23	12	Females	8	0	32

On the other hand, significantly larger numbers of the older (25 to 30 years old) group required hospitalization than did the younger single adults; usually not with educational complications. Forty-three per cent of older (aged 25 to 30) women and 56 per cent of older men, as compared to 11 per cent of younger (aged 18 to 24) women and 18 per cent of younger men, had previously been hospitalized. Moreover, older men and women required re-hospitalization for their disorders more frequently than did those between 18 and 24 years of age. Thirty-nine per cent of the 25 to 30 year-old men and women had to be returned to psychiatric hospitals, as compared to 23 per cent of the younger group. There were insufficient numbers of subjects for these figures to be significant statistically.

Among the older groups, 47 per cent of 15 Catholics had been hospitalized and 50 per cent of 22 Protestants and Jews. However, in the 18 to 24 year-old groups, in which educational problems were more prevalent, 18 per cent of 33 single Catholic men and 18 per cent of 27 Catholic women were hospitalized, but only 14 per cent of 22 Protestant and Jewish men and four per cent of 25 young non-Catholic women.

Thus, in the group of psychiatric out-patients studied, educational complications seemed to be increasingly important in the development of psychiatric disorders of young men and boys in recent years of greater competition to obtain education. This observation tends to support an affirmative answer to the first question.

The more rapidly socially climbing educational newcomer groups, the Catholics from the lower economic and social classes in particular, seemed to be encountering stresses associated with education more frequently than

*Significantly larger proportions of single Jewish young men sought psychiatric help in each subsequent time period. No similar trend appeared with single Jewish women. Higher percentages of Jewish and Catholic young men sought psychiatric help than did young women of the same faiths.

**I—education difficulties were described by the patient as the primary presenting problem. II—educational difficulties were mentioned as contributing to the present problem, but not as a primary factor. III—education was unrelated to the patients' problem.

Very significantly larger percentages of the younger groups of single men and women, who had previously been hospitalized, had educational difficulties than did the older group. Significantly more single men than women who had been hospitalized had educational difficulties.

those Protestants who were better established through cultural traditions and social position. Thus, the answer to the second question is also affirmative: educational newcomers *are* particularly susceptible to education-related emotional disturbances.

Hospitalization for psychiatric disorder was related to the educational difficulties of younger men. However, education-related hospitalization in the younger groups, usually associated with efforts at social advancement, was not nearly as serious a problem as was hospitalization in older groups. This supports the findings of Blaine and MacArthur [1] and the observations of Wedge.[11] Thus we are provided with an answer to our third question: education-related emotional disorders *were* less serious than those not associated with education in these patients.

We also studied *social and emotional factors in the lives of college students with intellectual and emotional difficulties.* Results from questionnaires administered on admission to Wagner College indicated that the male "special students" (with poorest high school records) were significantly different in backgrounds from the regular students (See Table 6). The latter, better qualified on the basis of high school records and I.Q.'s, were also more likely to:

a. Have better educated parents
b. Come from more intellectually enriched homes
c. Have better motivation for intellectual activities
d. Seek and accept advice and counsel

"Special" students were significantly more likely to be Catholics than were regular students. Special students, who often had to live at home, frequently had disinterested parents with whom they could not confer, and from whom they could not get help and advice with their educational and other plans and problems.

By the end of the first semester certain items were more, and others were less related to students' achievements. (See Table 7).

TABLE 6.

BACKGROUND FEATURES IN LIVES OF WELL-QUALIFIED AND POORLY QUALIFIED MALE FRESHMEN*

	Poorly Qualified	Well Qualified
Number	50	51
Mean Otis Intelligence Score	110	118
	Per Cent	Per Cent
Unenriched intellectual atmosphere of home	87	39
Parents' Education		
College	32	43
High school graduate	35	44
Less	33	13
Students' interests and activities not intellectual	67	43
Students do not seek advice and help	28	6
Religious Background		
Catholic	43	25
Protestant	52	68
Jewish	5	7

TABLE 7.

FIRST SEMESTER FINAL GRADES OF STUDENTS WITH DIFFERENT BACKGROUND FEATURES**

	Failing	Probation	Average	Dean's List
Number	14	31	35	27
	Per Cent	Per Cent	Per Cent	Per Cent
Unenriched intellectual atmosphere at home	74	70	48	38
Parents' Education:				
Some college	44	48	42	33
High school	29	31	40	49
Less than high	27	21	18	18
Students interests and activities not intellectual	65	61	40	15
Students do not seek advice and help	20	8	6	7
Religious Background:				
Catholic	52	31	20	7
Protestant	44	55	27	93
Jewish	4	14	3	0

*Regularly well-qualified students were significantly different from special poorly qualified students in each of these background features.

**There were no significant differences between the parents' occupations or educations of poorer and better students. Family environmental features decreased in relative importance when compared to features related to the students' own interests and behavior. Catholic students continued to have the most academic difficulties and Protestants the least.

When the freshmen's background features were compared to their final grades these patterns emerged:

a. Home enrichment and parents' education were considerably less useful in discriminating between students with high and low college grades than they were with the same students' high school grades.

b. Students' own interests, activities and motivation were more useful in discriminating between high and low college grades than they were when high school grades were compared.

c. *Students' Seeking Help and Advice.* This continued important in contrasting students with high and low grades.

There were no longer significant differences in the occupations or educations of parents of students with different grades at the end of the first semester. These findings seem to explain why some students with fair to good high school grades falter in college. Their homes may have been enriched by educated, intellectually ambitious parents. These students applied themselves when under parental supervision. But those who apparently had not learned to persevere diligently by themselves, and pursue intellectual goals in a well-organized fashion, did poorly when removed from parental supervision.

Other students, whose parents were not highly educated, but who themselves had acquired intellectual interests and a drive to achieve, continued with good records.

College students who were making poor grades, who dropped out of school, or who were dismissed for academic, emotional or other reasons tended to come from homes in which the family's traditions, interests and values were likely to be unintellectual. Failing students often were having to sustain their own academic interests without parental support, occasionally even in the face of parental opposition. In addition, they more frequently were commuting students who lived off-campus with their disinterested parents. They more regularly were required to work in order to help pay expenses of their educations.

Certain students, who had well-educated parents with intellectual interests, failed to develop intellectual motives and interests themselves. They often made good grades in high school, but faltered in college.

COMMENT

In general, then, with regard to the Wagner College students and the psychiatric patients studied, it would appear that students from less privileged families, unenriched intellectual backgrounds and conflicting values and traditions, were particularly susceptible to academic and emotional difficulties as they sought higher educations. Yet, increasing numbers of young men in particular are striving to climb and achieve educationally. Among the psychiatric patient group (some of whom were sensitized emotionally earlier in life) the educational stresses helped to pressurize already straining psychophysiologic processes. In some cases, an additional stressful event—an unfortunate love affair, a death in the family, or a serious personal physical illness—apparently helped precipitate an emotional disorder. Sometimes a special educational problem itself—the stress of examinations, for instance—triggered a psychologic collapse in the susceptible.

Selzer [10] has helped explode the "Happy College Student Myth." Wedge [11] and Blaine and McArthur [1] studied Yale and Harvard students who came predominantly from middle and upper class families. They reported that about ten per cent of these students also were disturbed by problems related to their seeking higher educations.

State universities are often required by law to admit *all* high school graduates who apply. They frequently report up to a 75 per cent drop-out rate. Nationally, most studies reveal, on the average, that four out of ten students will not graduate. Educators throughout the nation are studying this [12,13] and often report similar findings [8,9] to those described in this paper regarding reasons for student failures and

drop-outs.[4,15 to 18] Several of the present authors' previous researches[4] have shown that beginning, but failing to complete one's education is highly related to the development of emotional disorder.[5,6]

If further studies support the finding that increasingly higher proportions of students are succumbing to emotional disturbances, it will be important to develop methods of reducing the stress of obtaining higher education. The authors are aiming at programs to prevent emotional, intellectual and social disturbances at Fairleigh Dickinson University and Wagner College and in several cooperating Bergen County High Schools. Until more specific measures can be developed in the school and home to cope with these problems, the family doctor can help his student patients by encouraging them to proceed with education cautiously. The student, parent and educator can be reminded that the student can falter if he tackles a load for which he is poorly prepared or if he aims at too fast a pace. A student can be overloaded with studies and anxieties about his studies to the point of emotional collapse if he does not pace himself properly, and watch his mental and physical health.

SUMMARY

LARGE numbers of students, particularly young men and boys, are developing emotional problems associated with the stresses of obtaining a higher education. It appears that educational new-comers were more likely to develop education-related emotional disturbances. Educational new-comers also tended to fail or quit college. This seems to be significantly related to subsequent emotional disorder.

275 Grand Avenue

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Charles E. Clark, M.D

Ridgewood

Injuries of the Esophagus*

This compact presentation clearly spells out the differential diagnosis of an uncommon but potentially serious injury.

Anatomically, the esophagus has both assets and liabilities in relationship to injuries. It occupies a *deep* location within the chest and neck. This serves to protect it from external violence. On the other hand, it has comparatively low tensile strength, only a fair blood supply and no serosal coat. These limitations act as handicaps.

Injuries of the esophagus from *external penetrating sources* are unusual. Stab wounds and bullet wounds of the cervical esophagus rarely occur. Similar wounds of the thoracic esophagus are generally associated with severe additional injuries and seldom receive definitive treatment because the patient usually dies before treatment can be instituted. Rupture of the esophagus from *nonpenetrating external injuries* such as crushing has also been described and its treatment is similar to that discussed below.

Injuries to the esophagus may occur from *ingested materials,* either caustic substances or foreign bodies. Burns due to ingestion of lye are less common than they used to be. This is apparently due to the decreasing use of lye as a cleaning agent; and perhaps also to publicity about the danger of leaving lye within the reach of children.

Treatment of a caustic injury is: (1) neutralization of the caustic with, perhaps, sodium bicarbonate solution if it were an acid; a soothing oil solution; and (2) in one or two weeks to start gentle dilatations with bougies.

Fairly common similar injury to the esophagus may occur from taking aspirin tablets without water. I have seen acute ulcers of the esophagus apparently from this source. They generally respond to mild alkalies and bland diet for a few days.

Foreign bodies may damage the esophagus from the things ingested by children, to foreign bodies introduced diagnostically or therapeutically. This may happen during endoscopy or bouginage or, occasionally, by the insertion of a Levine tube. This type of injury is most likely to occur at the upper esophagus, at the cricopharyngeal level or at the hiatus.

Instrumentation of the esophagus must be done gently. Prior to instrumentation in an elderly patient, a lateral cervical x-ray should be taken to detect hypertrophic spurs on the anterior surface of the vertebrae. Such spurs may be just enough to cause perforation as the instrument slides by.

Ingested foreign bodies are more likely to become arrested at the cricopharyngeal level or in the midesophageal region near the bifurcation of the trachea or at the hiatus. These are often removable by esophagoscopy. Sometimes they may be gently pushed down into the stomach. On rare occasions, they require open operation for removal.

One additional injury of the esophagus should be emphasized. This is the so-called spontan-

*Read May 16, 1962 at the Annual Meeting of The Medical Society of New Jersey.

eous or post-emetic rupture of the esophagus. It was first described in a classic manner in 1724 by Boorhave. His patient was the Grand Admiral of the Dutch Navy who had overindulged in food and drink. Then he tried to relieve himself by vomiting so he could eat and drink some more. After vomiting, he immediately developed a severe pain in his lower chest. This radiated through to the back and got steadily worse. Within a few hours, he became dyspneic and cyanotic and developed a subcutaneous emphysema of the neck. He developed a shock-like picture and within a few hours was dead. At autopsy, he was found to have a linear rent in the esophagus on the left side, just above the hiatus of the diaphragm with fluid, air and gastric contents in the left chest cavity.

This remains the classical description of the onset, course and findings in this condition. It generally occurs after the stomach has been distended with food and drink. Pain develops on or shortly after vomiting. The pain is severe and the patient soon goes into peripheral collapse. This may be confused with an acute coronary occlusion, pulmonary embolus or ruptured peptic ulcer. Many have been operated upon abdominally for a presumed ruptured ulcer. When a patient is explored for a perforated ulcer and none found, it behooves the doctor to look further and the esophagus is then always suspect. The rupture typically occurs on the left side just above the diaphragm. These have been exposed and repaired through an abdominal incision by mobilizing the esophagus at the hiatus and pulling it below the diaphragm. This, however, does not give satisfactory exposure and is not recommended.

Mackler† ran a series of experiments on soft, fresh esophagi obtained at autopsy. He subjected them to pressure and found that five pounds per square inch would cause the average esophagus to rupture. In most of his experiments, the rupture occurred at the classical location just above the hiatus and on the left side. This pressure may be exceeded in vomiting; but with the upper end of the esophagus open during vomiting, rupture is not common. Muscularis splits first and then the mucous membrane.

†Mackler, S. A.: *Surgery, Gynecology and Obstetrics*, 95:345 (March) 1952.

DIAGNOSIS

THE great problem here, as with other injuries of the esophagus, is to establish the diagnosis. Severe chest pain on or immediately following instrumentation or vomiting should place the physician on the alert. A chest x-ray should be immediately taken after examination. The identification of air within the mediastinum or neck pretty well establishes the diagnosis. If fluid is present in the pleural cavity, it should be aspirated and if gastric contents are noted, the diagnosis is clear. If there is any question, the patient may ingest methylene blue and if the dye is obtained from the chest, the diagnosis is proved. Subcutaneous emphysema of the neck is a comparatively late sign but should always be searched for. If there is still doubt as to the diagnosis, the patient may be given a small amount of water soluble contrast media to swallow and an x-ray taken.

TREATMENT

FOR any injury of the esophagus in which a defect has been produced in the full thickness of the wall of the esophagus, I believe the only treatment should be open operation. This applies whether the injury is produced endoscopically, instrumentally with a foreign body or is of the "spontaneous" type. Other authorities prefer to place the patient on nothing by mouth and to give him large doses of antibiotics. With this treatment, mortality has been high.

The site of injury should be exposed and debrided. The esophagus should be closed with two layers of non-absorbable sutures and, if in the neck, the wound drained. If it is in the chest, the mediastinal pleura should be left open and the chest drained with under-water

seal suction. The only possible exception to this should be a late neglected case where an abscess has developed in the mediastinum or the neck. Under this circumstance, a primary repair would not hold; therefore a Levine tube should be placed down the esophagus into the stomach and the area drained. Very likely a secondary repair would have to be carried out.

With early treatment by this method (that is within 12 to—at most—18 hours) results are good and the mortality is low. For treatment after 24 hours, the mortality is high: hence the urgent need for early diagnosis.

530 North Maple Avenue

Diet Curbs Coronaries

Returns are now in from a four-year field study on the effect of a low-fat diet aimed at curbing blood cholesterol.

The major conclusion from evaluation of Anti-Coronary Club members: Dietary control is a "feasible approach" to reduction of coronary heart disease.

Among middle-aged study participants who were not previously afflicted with coronary disease, there was an incidence of 3.4 attacks per 1000. Based on data obtained from the famous population study now in its 13th year, an overall incidence of 14.5 per 1000 would be expected.

Dr. Christakis pointed out that there are many risk factors associated with coronary disease, but the club is dealing only with those relating to diet. Diet-related risk factors are cholesterol over 260, diastolic blood pressure of 95 or more, and obesity.

"Individuals having two of three of these risk factors have a 15-times greater chance of developing heart disease than those who have none," he said.

Under the prudent diet for normal-weight persons, fat content is lowered from the usual 40 per cent to 30 per cent of the total diet of about 2700 calories. One-third of fat is polyunsaturated, one-third monounsaturated and the rest saturated.

"The overweight subject was placed on a diet averaging 1600 calories and containing 19 per cent of the calories as fat" in the same proportion, Rinzler explained. Participants are told to avoid butter, cream, ice cream, cream cheese, hard cheese, and as much animal fat as possible.

Frequent fish and seafood meals ("good sources of polyunsaturated fatty acids"), limited servings of veal and poultry, and only 16 oz. of beef, lamb, mutton or pork per week are required. Vegetable oil is recommended for cooking.

For the first 400 men aged 50 to 59 years who entered the study, the benchmark cholesterol level averaged 260 milligrams per cent. About 20 per cent had levels under 220; almost 8 per cent, under 200.

For purposes of analysis, the distribution of cholesterol values was divided into thirds, with the dividing points at 230 and 270. Among men of normal weight in the original group, the prudent diet lowered the serum cholesterol in about 80 per cent of the subjects with control levels in the upper third, 60 per cent of those in the middle third, and 30 per cent of those in the lower third.

Two hundred and eleven men in the original group were obese. In 111 of these, average serum cholesterol fell from 261 to 225 after six weeks on a prudent diet. The drop in cholesterol in the upper third was from 307 to 260; in the lower third from 207 to 189.

"Progressive desaturation of depot fat was observed in subjects on the experimental diet," the authors add. "The linoleic acid content rose to 24 per cent after two years in men with records of good adherence, as compared with 9 per cent in those on a conventional diet."

Next step in diet-coronary disease research will be a mass nationwide program due to begin this year under the direction of the National Institutes of Health. Thousands of Americans will be provided with fully prepackaged diets in order more accurately to assess food intake—and the results.

—*World Medical News*, June 8, 1962.

Edwin N. Murray, M.D.

Camden

Painful Joints in Liver Disease*

Painful joints suggest a snap diagnosis of some kind of arthritis, bursitis, or similar disorders. But, as Dr. Murray here points out, if the patient is conscientiously studied, the real etiology can usually be worked out.

We may see patients with joint symptoms attributable to their hypothyroidism, to their collagen disease, to their psoriasis, to their amyloidosis, to their Raynaud's disease, to their shoulder-arm-hand syndrome, to joint disuse, and to drugs or sera they have received. Our conclusion from this array is that we must *study* the patient. I here review two cases which suggest another cause for joint symptoms. The first patient had cholangeolytic hepatitis which presented as arthritis. The abnormal liver tests came as a surprise. The second patient had post-necrotic nodular cirrhosis and active hepatitis and chronic pancreatitis. Over a four-year period, she suffered several flare-ups of hepatitis and each flare-up was accompanied by very troublesome joint pain.

CASE ONE.

A 39-year old housewife was admitted to The Cooper Hospital in Camden on November 21 and discharged on December 16. Her chief complaint was of pain in the joints and in the muscles of the legs for twenty days before admission. Prior to November 1, she had considered herself in good health. On that day she began to have pains in the hip joints, left wrist and both shoulders and some swelling of both feet. The swelling subsided within ten days and the joint pains decreased with aspirin at home but persisted to a lesser degree until admission on November 21. Her past medical history was unrevealing.

Physical examination disclosed some tenderness of the hip joints, mild tenderness in the epigastrium and a few ecchymoses on the extremities. The epigastric tenderness prompted the ordering of "liver tests."

Significant serial laboratory findings were as follows: Alkaline phosphatases 23, 25, 10. Thymol turbidities 5, 5. 5. Serum bilirubins 3, 1.5, 1.2. Transaminase Ps 630, 380. Sedimentation rates, by the Cutler method, 20, 26. B.S.P.'s were 47 per cent and 8 per cent. Globulin was greater than albumen (3.2 to 3.0). The following were normal or negative: rheumatoid factor, L:E cell preparation; cold agglutinations; heterophile antibody; antistreptolysin titre; serum calcium and phosphorus; plasma uric acid; blood Mazzini; stool for occult blood; Congo Red test; P.B.I., and electrocardiogram. Electrophoretogram revealed a decrease in concentration of serum albumen but marked increases in Alpha-1, Beta and Gamma globulins. The following were negative: Chest x-ray, x-ray of both hands, of skull, of hips, lumbosacral spine. The gall bladder failed to visualize.

Liver biopsy showed "Areas of necrosis with infiltrations of chronic inflammatory cells; also areas of parenchymal cells having enlarged or multiple nuclei—suggesting active regeneration. Periportal inflammations of both acute and chronic inflammatory cells are marked and slight bile duct proliferation is evident. Subsiding hepatitis is suggested, including subsiding cholangeolytic hepatitis."

By the time these tests had been completed, all joint discomfort had disappeared without medication and her liver disorder had improved—also without medication.

CASE TWO

A school teacher, age 48, was first admitted in 1953 to the Cooper Hospital on the service of Dr.

*Read May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

William Snape because of pain and stiffness in the back of the neck. Within 24 hours, the stiffness had spread to involve all joints. The hands began to swell and the patient was febrile. Plasma uric acid was normal and L:E preparation was negative but two B.S.P.'s revealed 45 per cent and 55 per cent dye retention. Laparotomy and liver biopsy established a diagnosis of "chronic hepatitis." Shortly after liver biopsy, the patient improved markedly; the fever and joint pains subsided completely.

She was readmitted in 1955 for fever and stiffness of multiple joints. The liver was just palpable. There was reversal of the A-G ratio. Cephalin flocculation test was 3 plus; thymol turbidity 100 units. Alkaline phosphatase 19.8. Bromsulfalein retention was 25 per cent. The diagnosis was again hepatitis, recurrent.

Another admission, in June 1956, was for a "check-up." She had no complaints. The liver was barely palpable. Albumen and globulin were both 3.0. Cephalin flocculation was plus 2 at 24 hours. B.S.P. retention was 15 per cent. Alkaline phosphatase was 17.4 and thymol turbidity was 15.0. So, there was certainly still liver trouble, asymptomatic, but with the tests showing improvement since 1955. A later admission in 1956 (September) was for "stiffness all over the body"—more as the day went on, with temperatures from 101 to 102 degrees in the afternoons. Blood culture was negative. A-G ratio 2.5 to 4.1. B.S.P. greater than 10 per cent retention. Alkaline phosphatase 14.7. Again the fever and joint symptoms subsided without therapy.

The final admission, in 1957, was terminated by death. At the time of re-admission the complaints were fever and stiffness of almost all joints without any swelling of joints. Cephalin flocculation was plus 4 in 24 hours. B.S.P. retention was 30 per cent. A-G ratio was 1.8 to 5.4. The autopsy report reads, "Post-necrotic nodular cirrhosis and evidence of active hepatitis and chronic pancreatitis."

These two cases do not prove that active liver disease is a frequent cause of or even an important factor in the etiology of joint disease. However, I present them because I feel that they *do* emphasize the necessity of *studying* the patient who has painful or swollen joints.

Schenker, Nasou and Lasersohn[1] reported a 36-year old woman who had transient L:E cell phenomenon developing in the course of acute self-limited hepatitis, presumably of viral origin. It was during the same hospital admission which showed the L:E cell phenomenon that she had "stiffness in her shoulders, elbows and hip joints. There were, however, no objective signs of arthritis." The authors suggest an autoimmune basis to explain the phenomenon. They know that the idea of autoimmunity in hepatic disease is not new since they quote Eaton and Murphy[2] as having the same opinion.

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130 North Broadway

Parkinsonian Pamphlet Available

What You Should Know About Parkinson's Disease, a precise and frank guide for laymen and physicians, has been prepared by the National Parkinson Foundation. It is available without cost. This material was prepared by Lewis J. Doshay, M.D. It answers such questions as the nature of Parkinson's Disease, the effect of prompt treatment and the outlook for victims. It reviews questions concerning inheritance, contagion and paralysis from Parkinson's Disease.

Dr. Doshay is attending neurologist, Neurologic Institute, New York City.

What You Should Know About Parkinson's Disease is one of a series of aids available to Parkinson victims, their families and the general public without cost under the program of the National Parkinson Foundation. Other material available includes: "A General Exercise Guide for Parkinson's Disease Patients" and reprints of medical articles prepared by members of the Medical Advisory Board. For a copy, write to the Parkinson Foundation at 135 East 44 Street, New York 17, N. Y.

Hammell P. Shipps, M.D.

Camden

Urinary Stress Incontinence in the Female*

Stress incontinence, an embarrassing disorder in the female, can usually be corrected by the surgical procedure here outlined.

Involuntary loss of urine occasioned by stress is a distressing problem to the patient. This has occupied the attention and taxed the ingenuity of physicians for several decades. The multiplicity of approaches and technics of attempted correction are a commentary on the effectiveness of our methods.

Urinary stress incontinence may be defined as the loss of urine by way of the intact urethra under conditions producing increased intra-abdominal pressure; for example: straining, coughing, sneezing, lifting and so on.

Stress incontinence is classified as either congenital or acquired. The acquired type is the more common, and in females, falls into three groups: (a) Postpartum, (b) Post menopausal, and (c) postoperative.

In true stress incontinence the following are present, singly or combined:

1. Descent of the posterior urethra and bladder neck.
2. Loss of the posterior urethrovesical angle.
3. Funneling of the urethrovesical junction.
4. Distortion of the urethra by adhesions.

If a woman complaining of involuntary loss of urine does not have at least one of these findings, the physician should be wary of the diagnosis of true stress incontinence.

In stress incontinence there is adequate urethral closure at rest but leakage under circumstances causing increased intra-abdominal pressure. In most cases the greatest intra-urethral pressure (resistance) at rest is found between 10 and 15 millimeters from the cystourethral junction.[1] In stress incontinence, this intra-urethral pressure is significantly lowered. At rest this pressure is higher than the intravesical pressure. During coughing the intravesical pressure rises. When this occurs in stress incontinence, the intravesical pressure exceeds the intra-urethral pressure. The voluntary muscles are capable of increasing the intra-urethral pressure.

Bladder control depends almost entirely upon the efficiency of the sphincter muscle mechanism at the bladder neck. This efficiency can be impaired by stretching or loss of tone resulting from pregnancy and the trauma of labor and delivery; or by menopausal atrophy.

Some women with large cystoceles and some descent of the posterior urethra and bladder neck are continent. Why? They seem to have a compensatory, or perhaps a pathologic continence. These same women may become incontinent after repair of the cystocele if an adequate cystourethropexy is not also done.

*Read May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

DIAGNOSIS

THE fact that a woman wets her clothing does not establish a diagnosis of stress incontinence. Information must be obtained about the onset of the symptoms and the circumstances under which it occurs. Are there other symptoms—such as frequency, urgency or dysuria? Stress incontinence must be differentiated from urinary fistula, neurogenic bladder, cystitis, trigonitis and posterior urethritis. And in this respect the history can be almost as helpful as the examination.

Pelvic examination includes a careful evaluation of the vaginal walls and the pelvic floor, especially in relation to the supporting structures. The caliber and tone of the urethra should be carefully noted with the patient at rest and, again, on straining and coughing. Additional information is obtained with the patient standing. In a normally continent woman the posterior urethra and bladder neck are well supported above the pubic arch. This support is somewhat flexible and it is not distorted by periurethral adhesions. When a catheter is inserted, its direction is toward the patient's head and not toward the sacrum. There may or may not be an accompanying cystocele or uterine prolapse. Relaxation in this area produces changes in the posterior urethrovesical angle. It becomes less acute and may be obliterated. This change of position of the bladder neck places the posterior urethral sphincter in the direct line of force when the intra-abdominal pressure is increased by coughing or straining, as has been well shown by Muellner.[1] Loss of urine then occurs. This may be demonstrated with cystourethrograms.

In patients complaining of involuntary loss of urine without the typical symptoms and signs of *stress* incontinence, the bladder and nervous system should be meticulously investigated for other pathology, especially if the incontinence is associated with urgency and dysuria. Patients with these symptoms may occasionally have also the mechanism of true stress incontinence; but it is wise to clear up other urinary pathology before embarking upon a surgical procedure for correction of the stress incontinence.

The clinical history and the physical examination will usually make the diagnosis; but some cases will require special studies by roentgenograms and cystoscopy.

MANAGEMENT

THE treatment of urinary stress incontinence may be surgical or nonsurgical.

Lesser degrees of incontinence in some women will respond favorably to conservative measures aimed at increasing the tone and vitality of the pelvic supporting structures. These consist chiefly of muscle training exercises and of the use of female hormones in women lacking in these endocrines. Such measures are also useful in improving and maintaining the results of surgical treatment.

The surgical treatment of stress incontinence is aimed at procedures which will correct the defects characteristically found in these cases. Many operations have been devised, both vaginal and abdominal. There is no one completely satisfactory operation for all cases. The approach and procedure will need to be varied according to the pathology present and the extent of the pathology. In my experience, the vaginal approach has seemed desirable in most cases, and, over the years, has given excellent results. With the vaginal approach one can also repair other defects in the vagina and pelvic floor which are frequently associated. Vaginal hysterectomy may also be included where indicated. The abdominal approach is used if abdominal pelvic surgery is indicated and if the pelvic floor pathology is related chiefly to the stress incontinence. In a few cases a combined approach is used.

Whatever the approach or the technic used, surgery, to be successful, must accomplish the following:

1. Restoration of the sphincter tone at the posterior urethra.
2. Provide adequate support for the posterior urethra and bladder neck behind the pubic arch.
3. Restoration of an adequate posterior urethrovesical angle.

1. Muellner, S. R.: Surgery, Gynecology and Obstetrics, 114:568 (March 1962).

4. Provide for normal mobility of these parts.
5. Place the vesical neck at a point anterior to the point of greatest stress when intra-abdominal pressure is suddenly increased.

Any operation which accomplishes these should be successful. Such operations we designate as cystourethropexy, vaginal or abdominal.

Operations on the anterior urethra alone for lengthening or angulating are unatomical, and have little place in the modern surgical approach to stress incontinence.

In vaginal cystourethropexy, the anterior vaginal wall is dissected from the cervix to the urethral meatus, keeping the dissection just beneath the vaginal mucosa, and leaving the pubocervical musculofacial supporting layer attached to the bladder and urethra. This dissection is carried wide and high around the posterior urethra and bladder neck into the retropubic space, so that the bladder neck is free to ascend into the pelvis. Interrupted 00 chromic catgut sutures are then placed in the supporting layer about the posterior urethra and bladder neck to lift this area into the pelvis, give it support, and restore the posterior urethrovesical angle. A Foley catheter in the bladder is an aid at this point. When these sutures are properly placed it will be noted that the catheter is directed toward the patient's head rather than toward the sacrum. If a urethrocele is present or if the caliber of the urethra is too great, sutures are placed beneath the middle and anterior urethra appropriately. The vaginal mucosa is then appropriately trimmed and approximated with interrupted catgut sutures.

In abdominal cystourethropexy the Marshall-Marchetti type of procedure is usually followed. In recent years I have rarely found it necessary to use any of the sling operations.

Patients treated for stress incontinence should be followed for long periods of time, and they should be encouraged to make use of pelvic muscle exercises. It is a mistake to consider patients "cured" after only a one-year follow-up. Over longer periods of time there is a tendency for the results to deteriorate. This may not be entirely the fault of the treatment; it may be due to atrophic changes in the patient's tissues. The natural demands made upon these structures from day to day may eventually produce recurrence of stress incontinence. The judicious use of hormones and the continued practice of perineal muscle exercises can prove helpful in improving long term results.

SUMMARY

URINARY stress incontinence is a rather frequent and distressing symptom in the female. In most cases, it can be corrected if it is understood that the condition results from relaxation of the sphincter mechanism at the posterior urethra and the descent of the bladder neck from its normal position behind the pubis; and if appropriate measures are taken to correct this abnormality. Lasting results are more likely to accrue if these patients are followed for long periods and if the effects of aging are combatted.

719 Cooper Street

Cataracts

Persons with developing cataracts need not fear that intensive use of the eyes will speed the disease, reports James F. O'Rourke, National Institutes of Health. Use of the afflicted eye even may slow down cataract development because most body tissues resist deterioration when kept alive. —*International Record of Medicine*, May, 1959.

William H. Spencer, Jr., M.D.

Short Hills

Management of Chest Trauma in The Recovery Room*

Thoracic injuries need swift, specialized management, starting right in the country. In this brief paper, Dr. Spencer shows how.

Adequate recovery room management of thoracic injuries begins in the operating room with the placement of small dressings on thoracic wounds. This is needed so that adequate physical examination of the chest may be done during the postoperative period. This permits one to watch constantly for such things as atelectasis, pneumothorax, hemothorax, and mediastinal shift. Radiographs of the chest only supplement this repeated physical examination.

Blood loss should be replaced as it occurs—both in the operating room and recovery room. To this end, measurement of fluids in the chest drainage bottles is essential. One is occasionally faced with a falling blood pressure and rising pulse where a decision between continuing blood loss and developing cardiac failure must be made. Such a differentiation is extremely critical since the treatments are entirely different. Blood loss is treated by transfusion. The treatment of cardiac failure quite differently evolves around digitalis, diuretics, and even phlebotomy. One of the more adequate ways to make this differential diagnosis is by serial determination of the blood volume. Many of the problems in doing this have been minimized by the recent development of methods utilizing either radioactive iodinated serum albumen or radioactive chromium-tagged red cells in conjunction with a small computer. The computer is programmed to consider background irradiation from previous determinations and produces the determined volume directly in liters. Such devices are, unfortunately, expensive ($3500 to $4000) and require licensure by the Atomic Energy Commission. Many radiologists already have such licenses and anyone may use such a device under their supervision. In the absence of this somewhat elaborate equipment, measurement of the venous pressure may be of great assistance. This can be done continuously with a simple manometer attached to a plastic catheter in the antecubital or external jugular veins.

More and more frequently, we resort to elective tracheostomy in the management of chest cases. I think we are saving more of our severely ill patients because of this. Recent articles[1,2,3] citing ever more frequent indications for elective tracheostomy support this feeling.

In chest trauma, one can think of at least three situations indicating tracheostomy, with or without ventilator assistance.

First: Multiple rib fractures with unstable chest wall (flail chest). Hudson[4] states that this produces 25 per cent of deaths from chest injury.

*Read May 15, 1962 at the Annual Meeting of The Medical Society of New Jersey.

Second: Inadequate remaining pulmonary tissue after resection necessitated by injury.

Third: Continuing secretions or blood in the tracheobronchial tree.

I like internal splinting as proposed by Mörch [5] in the treatment of flail chest. In this method, splinting of the chest wall is achieved by *mild* respirator hyperventilation *via* a tracheostomy. Let me emphasize the "mild" in hyperventilation. Respiratory alkalosis produced by vigorous hyperventilation may have its own deleterious effects. Lambertson [6] has demonstrated that healthy volunteers exposed to mildly reduced oxygen tensions did well until hyperventilated; at that point they promptly lost consciousness. Carbon dioxide is the controller of cerebral vascular tone. When carbon dioxide falls, cerebral vascular constriction is produced and cerebral hypoxia may follow. Too vigorous ventilation may produce hypotension also by the Valsalva maneuver.

Mörch [9] advocates ventilation by way of a loosely-fitted modified Jackson tracheostomy cannula and a volume cycled ventilator of his own design. This method, while satisfactory, presents practical difficulty in determining tidal volume, due to large leak of gases into the pharynx around the cannula. One must rely on visual inspection of the chest expansion, checked by arterial pH and carbon dioxide content (venous) for long term management.

Another approach is the use of a cuffed tracheostomy tube which will permit an airtight fit. An appropriate tidal and minute volume may then be established with great surety. The Radford nomogram [7] may be used to select appropriate ventilator settings. The ventilator, in turn, may occasionally be checked by a device such as the Monahan ventilation meter.

All patients on long term ventilator therapy should occasionally be hyperinflated. Bachman [8] has demonstrated that this temporarily improves compliance.

Finally, at the risk of restating the obvious, let me emphasize the importance of using sterile catheters to suction the tracheobronchial tree. One too frequently sees the catheter used for tracheal suction carelessly thrown over the back of the suction machine.

43 Mohawk Road

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Go Ahead and Shiver

Don't hesitate to shiver when it's cold. The truth is that violent shivering can result in a fourfold increase in body heat production, according to Robert E. Smith of the University of California.

Writing in the March 1962 *Journal of the American Medical Association*, Dr. Smith said shivering was a "major defense" against body cooling from cold exposure. He also said shivering is a more "economical" producer of heat than exercise because shivering involves no external work function.

Psychosomatic Profile • • •

"Nervous Stomachs"

The general practitioner, because of his intimate knowledge of the patient's family and friends, is in an unusual position to give supportive and often curative therapy. For example, there is a 30-year old man complaining of epigastric pains after meals. He experienced relief with antacids. X-ray revealed a duodenitis. He was helped with an ulcer diet, antacids, and antispasmodics.

He is employed by his father-in-law, and a "promotion" required him to work seven days a week, including some evenings. Thus, he had less time to spend with his wife and children. He was unhappy and subsequently developed the abdominal pains.

The relationship of his unhappiness to his abdominal complaints was explained to him. He was reluctant to make a stand against his father-in-law, but his seven-day week was reduced, on my advice, for "medical reasons." My knowing the father-in-law was a help in solving this young man's problem. He will probably need help again in the future. Psychotherapy or psychoanalysis could help this young man handle future problems in a more aggressive manner, but this is not deemed necessary at this time.

I think, too, of a 42-year old man who comes to my office at intervals because of spells of crying, depression, loss of appetite, and insomnia. He has upper abdominal pains as a psychosomatic response to his emotional problem.

This agitated-depressed state may last only a few days. It occurs every few months. It is precipitated by his "disgust" with his partner who is not sharing the load of the business problems. The partner takes off for a few days to see a baseball series without first considering the increased load on his partner.

These partners are close relatives and there is no possibility of a dissolution of the partnership. The patient just takes it out on himself. He gets tremendous relief by running in to see me and talking out his "gripes." A few tears and profanity give him more relief than any tranquilizer. He also needs antispasmodics, antacids, and a night-time sedative.

If the anxiety state becomes more prolonged than usual, I will encourage him to return to his psychiatrist for therapy.

—Matthew Molitch, *M.D.*

Obituaries • • •

DR. CHARLES DANE

Death came on October 8 to Charles Dane, one of our Society's senior members. Born in Canada in 1886, he earned his M.D. at Harvard in 1910. That same year he accepted an internship at the Orange Memorial Hospital. He liked New Jersey so much that he remained here for the rest of his life. He took an active part in civic and medical affairs in the Oranges. He was, for over a quarter of a century, a member of the Board of Governors of Orange Memorial Hospital. He had a tour of duty as director of its outpatient department. For a long time, he was president of the South Orange Board of Health. In 1960 he was a laureate of our Society's Golden Merit Award. Some years ago he was president of the Orange Mountain Medical Society. He was a lieutenant colonel in our Army's medical corps during World War I.

DR. ALFRED STAHL

The name Alfred Stahl was familiar to all members of our State Society for many years, since he long served as Secretary. He was a lifelong Newarker. He was born in Newark in 1879 and died there on October 12 this year. He received his M.D. at Baltimore Medical College in 1906. He did general practice from 1907 to 1917 and then entered the medical corps of the Army of the United States. After service there, he remained in Vienna to do graduate work in otology and laryngology and returned to Newark to practice that specialty. He remained in the reserve corps and was commissioned a major in 1942 (at the age of 63!) during World War II. He was affiliated with Newark Presbyterian Hospital and with the Hospital for Crippled Children.

Book Reviews

Measurements of Endocrine and Endocrine Functions of the Pancreas. Edited by F. William Sunderman, M.D., Sc.D. and F. William Sunderman, Jr., M.D. Philadelphia, 1961, J. Lippincott Co. Pp. 203. ($11.00)

Separate sections of this broad undertaking are devoted to exocrine functions of the pancreas, to endocrine functions, and to cystic fibrosis. In each are presented methods for determination for the secretions, evaluations of these methods, and comments on interpretation. Most are clearly presented and represent the most useful technics available at this time. The limitations in specificity of some assays (especially those for insulin and glucagon) are made clear. There are chapters reviewing secretin and pancreozymin stimulation tests, the laboratory approach to acute and chronic pancreatic disease, humoral insulin antagonists, glucagon physiology and islet cell tumors. Of particular excellence are the chapters devoted to cystic fibrosis. Here are detailed presentations of the numerous analytic procedures involved in the diagnosis of this sometimes subtle abnormality.

In a 200-page volume, complete presentation of physiologic, biochemical, and clinical aspects of the pancreas is impossible, but this cannot be a valid criticism. One might have wished that the editors had chosen to delete the historical and clinical notes and to broaden their presentation of biochemical and statistical evaluation of the assays described. In published form, however, the chapters (and the full lists of references) will be of definite value to clinical pathologist, clinician, and investigator.

THEODORE N. LYNCH, M.D.

Halothane. By Ronald Stephen, M.D. and David M. Little, Jr., M.D. Baltimore, 1961, Williams & Wilkins. Pp. 142. ($6.00)

This monograph is a noteworthy condensation and summarization of over 300 references. It also reports the authors' extensive experiences with Halothane. The outline is conventional and the thoughts of the authors are clearly and concisely presented. Diagrams and illustrations are to the point and readily interpreted. Included is a brief section of British opinion on the current use of Halothane, perhaps a courtesy to their longer and more extensive use of the drug. This work is really a primer on Halothane, but it represents the experiences of literally millions of clinical anesthetic administrations and hundreds of experimental studies. It is a complete, concise, and timely work and recommended for anyone interested in the subject.

WILBER F. TAYLOR, M.D.

Medical Genetics, 1958-1959-1960. Edited by Victor A. McKusick, M.D. St. Louis, 1961, Mosby. Pp. 534 with 65 illustrations. ($14.50)

Genetics is not a topic which interests most American physicians. Some feel that it is anti-Democratic and therefore anti-American to believe in it. We prefer to hope that each of us can go as far as his drive and skills permit, and that he is not doomed to disease, disability, or deficiency by reason of a genetic defect. Objection is also raised to the therapeutically nihilistic effect of belief in the importance of heredity. However, these should not shut our eyes to the existence of constitutional limitations. The doctor ought to know more about them (even though he can't *do* more about them). This is a reference volume (it has 2700 bibliographic citations!) covering the medical literature of 1958, 1959 and 1960. It comes from Johns Hopkins and represents collation of abstracts prepared by the Department of Medicine there. Most of the abstracts are short. They are arranged in broad divisions, such as connective tissue, nervous system and so on. Most of the abstracts are factual; some are critical. Though dry in content, the volume is meaty and it is a convenient reference volume. It is not suitable for light bedtime reading.

HENRY A. DAVIDSON, M.D.

The Mechanism of Action of Water-Soluble Vitamins. Ciba Foundation Study Group No. 11. Edited by A.V.S. de Reuck, M.Sc. and Maeve O'Connor, B.A. Boston, 1961, Little, Brown and Company, Pp. 120, illus. ($2.50)

This small book includes lectures on mechanisms in the liver alcohol dehydragenase system: the role of vitamin B_6 in catalysis of reaction of amino acids: actions of tetrahydrofolate cofactors in one-carbon transfer: pharmacodynamics of thiamine action: evidence from studies on model systems; biotin in biologic carboxilations; and a summary.

It is frustrating to a clinician to try to understand these lectures. You have to be a physicist, chemist, and a biologist all rolled up in one to interpret the pages of confused formulae found in this book. To understand "coenzyme functions, coupling to proteins brought up to high oxidation-reduction potentials" would be like comprehending nature's way of solving the problem of cell respiration in our atmosphere.

No ordinary practicing physician, not even one who has a good knowledge of clinical or human nutrition, could possibly understand what is written here. Certainly, I didn't!

S. WILLIAM KALB, M.D.

The Mold of Murder. Walter Bromberg, M.D. New York, 1961, Grune and Stratton. Pp. 230. ($4.75).

Adopting the standard psychoanalytic concept of the drive to murder, Dr. Bromberg suggests that we might develop technics of education against crime much as we have technics of sex education or education about the effects of tobacco. The thesis is salted by numerous dramatic case histories of murders and murderers, and supported by a solid discussion of possible methods of therapy.

HERBERT BOEHM, M.D.

Hypertension: Recent Advances. The Second Hahnemann Symposium on Hypertensive Disease. Edited by Albert N. Brest, M.D. and John H. Moyer, M.D. Philadelphia, 1961, Lea & Febiger. Pp. 660, illus. ($12.00)

The Oxford Universal Dictionary defines symposium as "A convivial meeting for drinking, conversation and intellectual entertainment" and it may well be that this is applicable to some such activities; judging, however, by the present volume there was more of the latter than of the former. The understanding of hypertension, its diagnosis and treatment have made rapid strides in the last few years and the Hahnemann Symposium explores these through papers and panel discussions. This text includes the much neglected subject of the natural history of hypertension especially important in these days of readily available antihypertensive drugs. There is an extensive discussion of etiology, much of which makes fascinating reading, particularly in relation to the role of intracellular sodium and catecholamine metabolism. Other papers relate themselves to the diagnosis and management of the various hypertensive conditions.

Renal vascular disease is discussed in great detail and the diagnostic tools in its evaluation are elaborated. In most cases of unilateral renal vascular disease, a good history with emphasis on the recent development of hypertension serves as an excellent screening procedure. Done intelligently, this should eliminate many unnecessary and complicated procedures.

The anti-hypertensive drugs are discussed and their pharmacodynamics and clinical applications reviewed. Important but frequently overlooked points come up in these discussions such as the fact that all thiazide compounds have essentially the same pharmacologic and clinical effect, the action of thiazides on uric acid metabolism and the relative uselessness of veratrum compounds except in acute hypertensive emergencies.

Probably the most appealing parts of this volume are the transcripts of informal discussions by the various participants.

For anybody interested in hypertension this is certainly a worthwhile addition to his library both for the review of the subject and subsequent reference. Maybe the alternate dictionary definition of symposium would thus be more applicable: "A collection of opinions delivered, or a series of articles contributed by a number of persons on some special topic."

GERALD E. MUEHSAM, M.D.

Cytology Manual. Based on a Series of Lectures by Ruth Winston. New Jersey, 1961, State Department of Health. Pp. 46., illustrated.

This handbook consists of lecture material presented in a cytology course for technicians. The 43 pages represent the meat of such information presented in a telegraphic and succinct style. There is a sparsity of illustrative photographs, probably due to the fact that these lectures were part of a course which included the study of actual slides. The drawings of cells, rather than the use of photographs, may be similarly explained. These limitations detract from the value that this *Manual* might have for a larger audience.

The text does not indicate the varied emphasis warranted by the much more frequent cytologic detection of some carcinomas (*e.g.*, cervix) than of others (*e.g.*, gastro-intestinal tract). Although such differences may be stressed during the course, the novice or uninformed reader does not receive such guidance. In a similar vein, there are four photographs of adenocarcinoma of the cervix and five of adenocarcinoma of the endometrium, but none of carcinoma-in-situ of the cervix which is far more frequent and significant. There are no illustrations of such common findings as Trichomonas vaginalis organisms and monilia spores. Only one diagram illustrates non-malignant atypia which is a most common occurrence requiring recognition in survey material for detection of uterine cancer.

A limited bibliography is listed. There is no index, but the course outline is a fit substitute for this brief manual.

This *Manual* is suitable for novice technicians, but could not be recommended for other trainees and provides no additional information to experienced cytotechnologists or pathologists. This is unfortunate because additional text and illustrative color photographs to guide the inexperienced reader would greatly widen the area of usefulness of this manual and would give many more students the benefit of Mrs. Winston's experience. The present book should thus be considered only a tentative beginning, and it is hoped that this will soon be expanded. This could then be a significant contribution by Mrs. Winston and the Cancer Control Program of the New Jersey State Department of Health.

JACQUES B. WALLACH, M.D.

Announcements

Crackdown on Out-of-State Laboratories

A Bergen County court has recently determined that it is a violation of the law for a laboratory licensed in New York City and not in New Jersey to do laboratory services for New Jersey physicians. The practice was for a New York laboratory to send messengers into New Jersey to pick up samples for analyses.

This has been officially held as a violation of the New Jersey Laboratory Licensing Law. Physicians who are using out-of-state laboratories on a package-plan basis are advised to check the statutes.

Seminar on Metabolism

You are invited to the 4 p.m. seminars on metabolism held at Bergen Pines, Paramus. A star-studded faculty has been recruited to give these lectures and answer questions. Here are the dates and topics: *January* 7: Protein metabolism. *February* 4: Tryptophan metabolism. *March* 11: The malabsorption syndrome. *April* 1: Metabolism in the Z-E syndrome; and *May* 13: Fat metabolism. For more details write to Dr. Abraham I. Friedman of 405 State Street, Hackensack, Chief of Gastroenterology at Bergen Pines.

Certification in Occupational Medicine

The next examination for Certification in Occupational Medicine will be held March 16, 17 and 18 in Washington, D.C., preceding the annual meeting of the Industrial Medical Association which will be held there March 18-21. Applications for certification are sent to T. Whayne, M.D., American Board of Preventive Medicine, 4219 Chester Ave., Philadelphia 4, Pa.

Identification of Dependents of Servicemen

The retention of certain servicemen beyond their normal date of expiration of active duty has been directed. For civilian doctors, this raises the question of the valid identification of the extendee's dependents who will remain eligible for medical benefits while their sponsors remain on duty. This duty extension may mean that some dependents will be without a valid Identification Card for some time. The basis of identification of dependents is the Uniformed Services Identification and Privilege Card known as DD 1173. Each card carries an expiration date. For the dependents of noncareer personnel, it is the same as the expected expiration date of the sponsor's tour of active duty.

In the past, the "expiration date" on the ID Card has been the prime factor in determining that eligibility still exists. Since the involuntary extension of the tours of duty of many servicemen is effective almost immediately, some still-eligible wives and children may apply for civilian medical care to which they are still entitled. They may not, however, have in their possession the required proof of their eligibility.

Service personnel will be advised that it is their responsibility to take the necessary action to up-date the evidence of dependents' eligibility. If a dependent is in need of authorized medical care from civilian sources prior to the time their card has been up-dated, the dependent should explain the situation to the physician and hospital authorities. They may be asked to show tangible evidence such as allotment checks, official orders, directives, or personal letters which support the claim of continued eligibility.

It is not expected that the number of dependents temporarily "unidentified" who require medical benefits will be large. Your understanding of this problem will be greatly appreciated.

No Medicare claims may be processed for payment unless the dependent has provided a valid DD form 1173 or a statement of eligibility from the sponsor's Commanding Officer. This is required by the Medicare contract.

County Society Reports • • •

Bergen

The regular meeting of the *Bergen County Medical Society* was held Tuesday, October 9. Dr. Samuel B. Reich presided. The following were elected to membership: Dr. Barry M. Josephson to "Active" by transfer from New York; Dr. Bertram Brinsley to "Active" by transfer from the Middlesex County Medical Society; Drs. Richard A. Botta, Marie E. DeVita, Michael R. DeVita, Andre Heltai, H. Richard Hoff, George W. Keyes, Pasquale Serpico, and Stanley D. Machlin to "Active" from "Associate"; Drs. Harvey T. Adelson, Johannes H. deJong, Thomas R. DiDonato, G. Jerry Falcone, Arnold Kopeloff, Salvatore M. Laraia, Thomas J. Lynch, Joseph E. Salvatore, Donald F. Shields, Donald I. Schiffman, Frederick A. Small, Ilhan H. Tuzel, and Elizabeth C. Venutolo to "Associate."

Dr. Phoebe Hudson summarized the activities of her Special Committee on Immunization, indicating that most of the plans for mass Sabin immunization had been cancelled until the Spring of 1963. However, Dr. Richard Berlin announced that the Teaneck plan would be carried out this month.

Dr. Leonard Brown, chairman of the Program Committee, then introduced Dr. Ernest C. Hillman, Jr., Associate Medical Director of The Mutual Benefit Life Insurance Company, who presented a panel on "Your Stake in Voluntary Health Insurance." The panelists, all members of the Health Insurance Council, were William C. White, Jr., Prudential Insurance Co. of America—"The Health Insurance Council and the Practicing Physician"; Edward G. Howe, M.D., Associate Medical Director, Prudential Insurance Co. of America—"How an Insurance Medical Director Views a Claim"; Laurence O'Mara, Assistant Claims Manager, Travelers Insurance Co.—"How an Insurance Claim Manager Views a Claim." Also present was Dr. Paul V. Reinartz, Medical Director of the Prudential Insurance Co. This was followed by numerous interesting and provocative questions from physicians directed at the panel. These included the subjects of fee schedules, duplicate coverages and insurance forms. The meeting was closed with the reciprocal promise of closer cooperation between insurance companies and physicians for the benefit of both patients and physicians.

WILLIAM L. PALAZZO, M.D.
Reporter

Burlington

The *Burlington County Medical Society* convened on September 13, at Millside Farms, Riverside. Dr. Lindley B. Reagan, President, was chairman with 53 members in attendance.

Preceding the meeting, Dr. Louis S. Wegryn, President of The Medical Society of New Jersey, and Mr. Richard I. Nevin, its Executive Officer, along with the speaker, Dr. Fred B. Rogers, were entertained at dinner at the Ivystone Inn, with 12 of our members attending.

Dr. Rogers, Professor of Preventive Medicine at Temple University Medical School, gave a talk on "The Medical Society of New Jersey since 1766." This was illustrated with slides of past presidents.

Dr. Martin Goldfield was appointed chairman of the proposed Burlington County mass oral vaccine immunization program, to be instituted in the spring of 1963, and will meet with representatives of other professional groups to formulate plans.

Discussion was held on the comprehensive expanded coverage now being offered by the Blue Cross in our Group Hospitalization Plan, and it was voted to accepted the increased benefits at a slightly higher premium.

A committee was appointed to work on having a contagious disease unit made available at one of our hospitals necessistated by the closing of Camden Municipal Contagious Disease Hospital.

Several members were appointed to a committee to draft a letter to the Board of Freeholders opposing the recent decision to curtail the number of autopsies budgeted under the outmoded county coronor system. Concurrence with members of the Bar Association was also to be requested.

The new fee schedule for welfare patients was accepted by the Society.

The *Burlington County Medical Society* met on Thursday, October 11, at Millside Farms, Riverton, to hear Congressman Frank Thompson, Jr. discuss "An Approach to Financing Medical Care for the Aged."

This new approach—the presentation of the other side of a major issue—was respectfully received. The Congressman, a foe of physicians fighting the King-Anderson Bill, pointed out that his views were based on information pertinent to the needs of the people rather than on the weight of letters received in his office. In addition to pointing out that there were 17 million people over 65 years of

age in the United States, he stated that this figure would be 20 million by 1970. It was contended that the proposed Anderson-Javits Bill (previously King-Anderson Bill) could be financed at a cost of $12 per person, per year, through social security; and that the total cost would not exceed seven cents of the annual tax dollar (of which National Defense and related projects now takes 73 cents). In the discussion which followed, the exchange of questions and answers was done without the emotionalism which so often accompanies this issue—although the Congressman noted that neither side had been persuaded to change its mind. A motion was carried to the effect that a news release should be sent to all county newspapers noting that, "the representative had spoken to the county medical society on medical care and that he was cordially received."

Reports were received from the Committee on Chronically Ill and Aging, and Diabetes Detection Committee. The time appointed to meet with the County Bar Association regarding proposed County Medical Examiners system is October 24. Advocates recommend that Mercer and Camden Counties be included.

At 10:15 p.m., the members adjourned to a collation of sandwiches, salad and dessert.

T. E. MATTINGLY, JR., M.D.
Reporter

Cumberland

The *Cumberland County Medical Society* held its October meeting at the Holly House in Millville with Dr. Ralph S. Phillips presiding. Dr. Thomas Donnelly and Dr. Renaud Blanchet were elected to *active* membership. Dr. David B. Rosenberg of Vineland was approved for *associate* membership and welcomed to the Society.

Dr. Peter Penico of Millville was appointed chairman of the diabetes detection drive, to succeed the late Dr. Egon J. Korican of Bridgeton.

The eye health screening program was conducted recently by Dr. Francis N. Campagna at the Newcomb Hospital, Vineland, and Dr. Samuel B. Pole at Bridgeton Hospital. They presented this report: number of patients examined, 168; number of completely normal findings, 87; number of subnormal findings, 57; number of findings of diseases of retina or lens, 23; number of diseases outside the eye, 4; glaucoma, 3.

Dr. Marvin N. Solomon of Vineland announced that a medical technician training course is being conducted at Newcomb Hospital in Vineland, and students who wish to obtain a Bachelor of Science degree may continue their studies at Rider College or Fairleigh Dickenson College.

The Society approved the fluoridation program of the State Department of Health.

LEONARD G. SCOTT, M.D.
Reporter

Gloucester

A special session of the *Gloucester County Medical Society* was held on September 12. This was called to deal with two new problems:

(1) Hospitalization of communicable disease patients needing other than home care, since the Camden County Municipal Hospital had been closed. A motion was passed referring this matter to the Public Health Committee, who will communicate with the Board of Freeholders.

(2) The giving of Sabin Oral vaccine. A motion was passed favoring the mass immunization program. A Wyeth film was shown illustrating the procedure of immunization as practiced in Phoenix, Arizona.

The regular monthly meeting of the *Gloucester County Medical Society* was held at the Woodbury Country Club on September 20. The meeting was called to order by Dr. Francis M. Brower, President. Dr. Bernard H. Pastor, Chief of Cardiology at the Veterans Administration Hospital in Philadelphia, spoke on the use of anticoagulants. Also participating was Alvin E. Granite, Prosecutor of the Pleas of Gloucester County. Mr. Granite, in discussing our state's adoption laws, warned that these matters should be handled only through a lawfully recognized agency.

In response to a communication from Dr. Earl Wentzell concerning a proposed merger of the Underwood and Memorial Hospitals, a motion was passed that we poll members' opinions.

Dr. Trigos reported the urgency of new problems with the Gloucester County Guidance Center. Dr. Holdcraft informed the members that old age assistance fees would be paid at the same rate as by the patient.

On October 18, members of the *Gloucester County Medical Society* entertained their wives and guests at the Annual Social Session. A total of 126 were present. Prior to dinner, everyone was welcomed to a cocktail party at the home of the President and Mrs. Brower. Music, flowers, excellent food and old time movies contributed to making the evening one to remember.

Dr. Louis S. Wegryn, President of The Medical Society of New Jersey, urged doctors to become interested in politics as a public service; and Richard I. Nevin, Executive Officer, sparked the evening with his usual wit and humor.

Dr. Brower expressed his appreciation to Dr. Lochhead and his committee, who planned and arranged for the entire meeting.

DOROTHY M. ROGERS, M.D.
Reporter

Middlesex

The regular meeting of the *Middlesex County Medical Society* was called to order at 9:00 p.m., October 17, by Dr. Ralph E. Siegel, President.

Dr. B. F. Slobodien, chairman of the Judicial Medical Ethics Committee, presented the following applications for approval; two years *Associate* membership—Dr. Franma W. Ginsburgh, Milltown, sponsored by Drs. De Liberti and J. Borrus; and Dr. Marion Jacob Ciepielowski, Metuchen, sponsored by Drs. H. J. White and Benjamin Copleman. To *regular* membership from two years associate membership: Dr. Paul Curtis, Highland Park, sponsored by Drs. S. Sklar and Kenneth C. Gould; Dr. Charles M. Weber, Woodbridge, sponsored by Drs. Leroy Homer and Cyril I. Hutner.

Dr. Milton Bronstein gave a report on the Future Physicians Club. This kind of project was initiated in Essex County where it is working very well. Twenty-seven schools in Middlesex county have been contacted; eight reported favorably. The county society will supply advisors to the schools. The program will include First Aid instruction. Senior members will develop Health Science Fairs and will distribute literature. On motion, this program was approved. Also approved was a recommendation that we sponsor a meeting with the Multiple Sclerosis Society.

The next item was a moving picture, obtained through the efforts of Dr. Vincent J. Cannamela. Featuring Dr. Edward Annis, it was titled: "Where is Medicine Going?" It was an interesting and informative film on the King-Anderson Bill imploring us physicians as we fight for freedom, not only freedom of medicine and our way of life, that even though we are trained to fight disease it will be increasingly necessary for us to learn to cope with the political subterfuge.

Following the film, Mr. Richard I. Nevin, Executive Officer of the Medical Society of New Jersey, spoke on organized medicine's solution to the problem of medical care for the aged.

The Kerr-Mills bill, Mr. Nevin said, was a good law and could be used to take care of the old people who need help. Those states that are using this have found it to be successful. However, New Jersey has failed to take advantage of it.

Mr. Nevin closed his speech with a quotation from President Kennedy's acceptance speech: "Ask not what my country can do for me but what I can do for my country."

EUGENE L. CHILDERS, M.D.
Reporter

Monmouth

After a brief summer respite, the regular monthly meeting of the *Monmouth County Medical Society* was called to order by its president, Dr. Donald W. Bowne, on September 26 at Monmouth Medical Center, Long Branch. Freeholders, representatives of the press, and the County Prosecutor were invited to the meeting as Dr. Edwin A. Albano, the Essex County Medical Examiner, discussed "Scientific Investigation of Violent Death." In addition to the presentation of well-illustrated cases, Dr. Albano pointed out some of the shortcomings of the present medical examiner system in New Jersey. He suggested that the post of Chief State Medical Examiner be established, that the state be divided into five districts each with an Assistant Medical Examiner; and that these offices be dovetailed into the existing county physician system.

Following the program there was a business meeting. Dr. Bowne urged chairmen of all committees to call their respective members together so that they might become active early. He announced that this year the county will be represented at state level on the basis of one delegate for each 20 county members instead of the present ratio of one delegate for each 15 members. It was also announced that beginning in November the on-call hours for the County Emergency Medical Service will run from 8:00 a.m. to 8:00 a.m. instead of the present 12:00 a.m. to 12:00 a.m.

The following physicians were elected to *Active* membership: Drs. Carl A. Coppolini, Red Bank; Michael Doyle, Neptune; Girolamo Pugliese, Keyport; and Walter M. Ryan, Jr., Neptune City. Drs. Stephen J. Dubel, Red Bank; Jay A. Kern, Asbury Park; Renato La Marca, Red Bank; Lynn A. Parry, Asbury Park; and Michael R. Quatrello, Asbury Park, were elected to *Associate* membership.

A discussion of "The Physician's Responsibility in the Mental Health Program" highlighted the regular meeting of the *Monmouth County Medical Society* on October 24 at Fitkin Memorial Hospital. Dr. Donald W. Bowne, President, called the meeting to order. The speakers were Dr. George Stevenson, President of the World Federation of Mental Health; Dr. J. Berkeley Gordon, Physician-in-Chief at Marlboro State Hospital; Dr. Robert M. Counts of the Child Psychiatric Center at Eatontown; and Dr. Avrohm Jacobson, who practices psychiatry in Asbury Park. Dr. Gordon outlined the methods of commitment to, and discharge from, the State Hospital. Dr. Stevenson and Dr. Jacobson spoke of the practitioners' responsibility in recognizing and referring mental patients who require specialized treatment and of the community hospital's responsibility in providing facilities for the treatment of acute psychiatric problems. Dr. Counts pointed out the shortage of mental health facilities for children in the county and suggested ways in which the situation might be improved. A lively question and answer period followed.

After the program there was a business meeting at which Dr. Gifford Grimm of Neptune was elected to Active membership. Drs. John C. Powers of Red Bank, Robert P. T. Reeves of Asbury Park, and Michael D. Walsh of Long Branch were elected to Associate membership. Dr. Joseph Gorga of New Monmouth was elected to Courtesy membership.

The death of Dr. John B. Boyd of Red Bank, who was the first Chief of Staff at Riverview Hospital, was acknowledged. The resignation of Dr. George G. Green as Secretary of the Monmouth County Medical Society, effective November 27, was announced. Dr. Green is to become an Associate Professor of Radiology at the University of West Virginia.

LOUIS R. SALMON, M.D.
Reporter

Passaic

The regular monthly meeting of the *Passaic County Medical Society* was held on Tuesday, September 11, at the Mt. Carmel Guild, in Paterson. Dr. Frank B. Vanderbeek, second vice-president, officiated.

The following were elected to membership: Associate—Drs. Robert M. Pollak, Abraham H. Topchik and Kenneth W. Hall of Wayne; Vincent J. Bagli and Alfio G. Dal Pan of Fair Lawn; John C. Roy, Aileen C. Thorburn and George L. Becker, Jr. of Paterson. Elected to Active membership by transfer—Drs. Harold H. Golz of Wayne and Philip A. Boyer, Jr. of Nutley.

Dr. Vanderbeek read a report of the Finance Committee for the fiscal year ending May 31, 1962, with its recommendation concerning the amount of dues for 1963.

The following resolution on the death of Dr. Joseph E. Donnelly was adopted as read.

On June 18, 1962, our friend and colleague, Dr. Joseph E. Donnelly, died suddenly of a coronary thrombosis.

Dr. Donnelly was born in Paterson, attended St. Peter's Preparatory School, Fordham University, and received his medical degree from Long Island College of Medicine in 1932. He interned at St. Joseph's Hospital, was resident physician for one year and actively practiced in Paterson for 30 years. He was an Associate Attending in the Department of Gynecology at St. Joseph's Hospital for the past 28 years.

During World War II, he served with the Army Medical Corps, spending two years in the Fiji Islands and in India with the Johns Hopkins Medical School Unit.

He continued his services at the Tilton Hospital at Fort Dix until his discharge from the Service.

Dr. Donnelly was appointed to the Fire and Police Commission in 1955, by Mayor Edward J. O'Byrne, and at the organization meeting was elected Chairman. In 1957, he was elected City Physician, the post he held at the time of his death. He also served as Assistant County Physician for a period of seven years.

Dr. Donnelly served the public of the city diligently during these 30 years, giving of his time, knowledge and professional competency to the sick and to others in need.

Dr. Donnelly's passing is mourned by his colleagues and the vast number of his patients, to whom he had endeared himself by his self-sacrificing service.

The Passaic County Medical Society therefore mourns the loss of this honored member, and resolves that this tribute be placed in its minutes and a copy be sent to his family, with the condolence of the Society.

Dr. Vanderbeek called upon Dr. Theodore Bender to read the following resolution on the death of Dr. Byron Close.

On July 31, 1962, at the age of 56, Dr. Byron Close of Pompton Lakes, N. J., passed through the darkness of death into that eternity "where each must take his place," and in his passing, this Society, the hospitals, and communities in which he so devotedly served have lost a physician of marked distinction and erudition.

Our colleague and friend was born in 1906 in Riverdale, N. J. He entered the College of William and Mary from which he was graduated with the degree of B.S. Cum Laude. Following this, he received his medical degree from George Washington University. He then interned at Memorial Hospital, Johnston, Pa. (1934-1935) and subsequently became a resident in medicine at Postgraduate Hospital, New York City. These educational periods were supplemented by postgraduate work at Harvard, Cooke County Hospital, Chicago, and Tulane University in Louisiana. After this extended ground-work he became a Diplomate of the American Board of Medicine.

He was on the courtesy staff of many local hospitals and was made chairman of the Medical Department of the Chilton Memorial Hospital, Pompton Plains, N. J., where in 1962, he became president of the Medical Staff.

A captain in the military service, Medical Department, he saw active duty in the Pacific Theater of the war. Wounded at the battle of Iwo Jima, he received a decoration of Merit and the "Purple Heart."

Whereas, this Society has taken due recognition of the intrinsic values of Dr. Byron Close, whose contributions to the advancement of the art of medicine and of the humanities have merited our highest commendations.

Be It Therefore Resolved: That the Passaic County Medical Society does inscribe in the minutes of its Procedures, the expression of our heartfelt sorrow and profound regret in its loss by death, of this illustrious member, Dr. Byron Close.

Dr. Vanderbeek then introduced the speakers for the evening, Msgr. William Wall, Director of the Mt. Carmel Guild, David Canavan, M.D., Medical Director of Mt. Carmel Hospital and Tom B, a representative of Alcoholics Anonymous. The panel discussed "A Successful Approach to Alcoholism." A question and answer period followed.

At the conclusion of the program, the members of the Society were taken on a tour of the facilities of Mt. Carmel Guild. A buffet supper was served, with the Mt. Carmel Guild as hosts.

ALEX SCHEFRIN, M.D.
Reporter

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ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

DECEMBER, 1962 • VOL. XXXV, NO. 10

PATTERNS OF ADENOVIRUS INFECTION IN THE RESPIRATORY DISEASES OF NAVAL RECRUITS

Two companies of naval recruits, one in training in the summer and the other in winter months, were found to have a comparable number of respiratory illnesses, but the severity of the episodes was greater in the winter than in the summer.

The purpose of this study was to evaluate the extent to which adenoviruses contribute to the total respiratory disease incidence of a particular recruit population.

The study population consisted of two companies of recruits in basic training at the Great Lakes Naval Training Center in Illinois. One company, with 55 men, began training in November, 1959, and completed it in January, 1960. It is termed the "winter company." The other, with 66 men, began training in July, 1960, and completed it in September, 1960, and is termed the "summer company."

The men in both companies were checked within 24 to 48 hours after arrival at the center. Groups of approximately 20 men each were interviewed by a medical officer or chief hospital corpsman. The men were interviewed three times a week. Before each interview the oral temperature was recorded.

A discrete respiratory disease was considered to have occurred if the symptoms differed in intensity, quality, or number from the usual pattern of respiratory symptoms in the same individual and were present for at least two days.

There were 117 discrete episodes of upper respiratory disease for the 50 recruits in the winter group and 151 for the 69 in the summer group. Although these companies were sampled at different seasons of the year, the average number of respiratory illnesses per man in both winter and summer study periods was similar, but there was more respiratory disease with fever during the winter study—29.1 per cent versus 14.5 per cent in the summer group. More than 50 per cent of the recruits had respiratory complaints during the early weeks of training, with a moderate drop off as their training program neared completion.

EXPLOSIVE EPISODES IN WINTER

The explosive onset of disease was particularly noticeable in the winter company, in which more than 86 per cent of the recruits were suffering from respiratory illness within one week after their arrival or before the end of their first week in training.

The prevalence of respiratory illness in both companies provides a clear picture of the ever-nagging presence of respiratory disease in a recruit barrack. Between 25 and 80 per cent of the men were found to have some respiratory ailment. Only two men in the summer company and three in the winter company completed their basic training without experiencing a respiratory disease.

The majority of illnesses in both companies

MICHAEL J. MCNAMARA, LCDR, (MC), WILLARD E. PIERCE, *HMC*, USN (ret), YORK E. CRAWFORD, M.S., and LLOYD F. MILLER, Capt., (MC), USN; *The American Review of Respiratory Diseases*, Oct. 1962.

could be classified as mild, nonspecific respiratory infections.

In the summer company, 14 respiratory illnesses were associated with adenovirus by isolation of the virus and positive serologic reactions and 13 more by positive serologic reactions alone. In the winter company, 10 respiratory illnesses were associated with adenovirus by virus isolation and serologic testing and 13 by positive serologic reactions. Therefore, of the total of 268 respiratory illnesses in both companies, 50 could be attributed to adenovirus. Type 4 was the only adenovirus isolated.

The peak incidence of adenovirus *disease* was found to be proportionately greater and more severe in the winter than in the summer group, although the number of men developing adenovirus *infection* was almost the same in both.

ROLE OF STRESS WEIGHED

Since this high incidence of respiratory disease coincided with the initial adaptation of young civilian males to the apparently less attractive life of a naval recruit, it is tempting to view this stressful period as significantly undermining an individual's resistance to respiratory infection.

If stress does substantially contribute to this initial outbreak of disease, its effects should be sought for primarily in the unreported respiratory disease. The respiratory disease as observed in these two study groups was similar, not only with respect to weekly incidence, but also with respect to the average amount of disease sustained by each individual during summer and winter months. Apparently this is contrary to what would be normally expected. Nevertheless, although there was no quantitative difference between these illnesses, the disease experienced by the summer company was less severe as measured by the number of febrile responses.

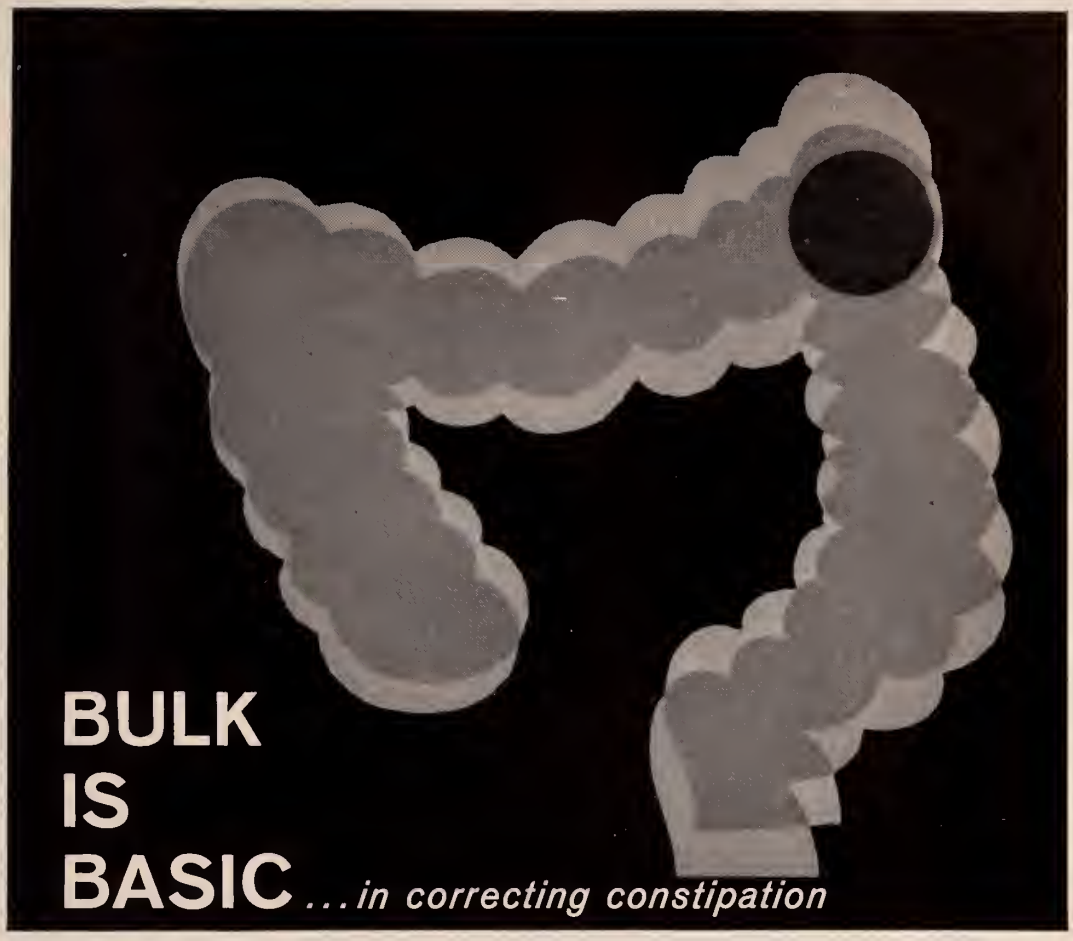
ADENOVIRUS PLACE PARADOXICAL

Crowding during the colder months has often been invoked as a significant factor in the transmission of upper respiratory diseases and, to some extent, in its severity. Nevertheless, during the warmer months the activities of recruit training are not significantly altered so as to decrease the degree of crowding. Changes in temperature and humidity have been shown experimentally to influence the prevalence of certain viruses, e.g., poliomyelitis and influenza. But with adenovirus the prevalence and type of infection were the same for both seasons, but the severity of illness varied.

The specific place of adenovirus infection in this recurit population is paradoxical. The mildness of the disease and its modest contribution to total respiratory illness belies the substantial role played by febrile adenovirus disease in reported illness.

The demonstration that previous illness not due to adenovirus apparently could enhance an individual's susceptibility accentuates the importance of studying the respiratory disease experience of an individual. The precise mechanism whereby some persons contract adenovirus infection while suffering from acute respiratory disease will require further study. The extent of the contribution of respiratory illness not of adenovirus origin in recruits to the high incidence of adenovirus infection in large recruit populations cannot adequately be answered from this investigation. Such an answer could possibly be forthcoming if it were possible to reduce significantly the incidence of the "nonspecific" respiratory disease with specific vaccine prophylaxis.

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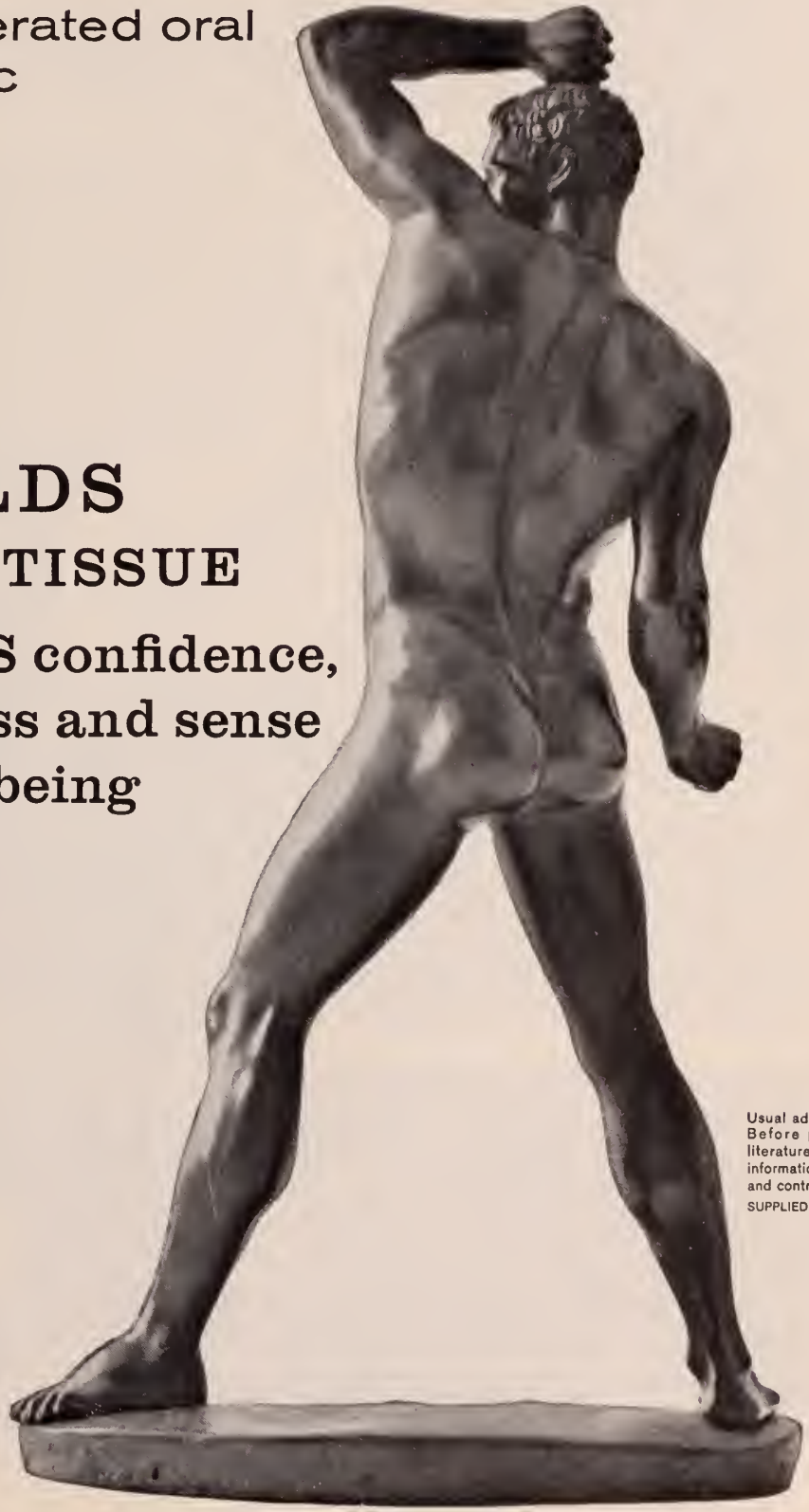
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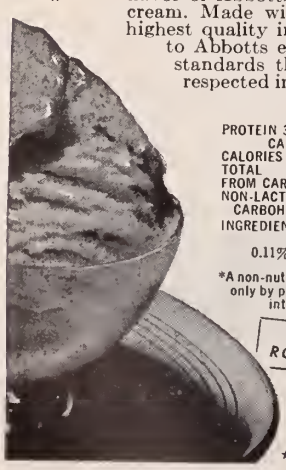
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INDICATION: *Accidental trauma*



INDICATED:
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curtails swelling, curbs pain

1. Beck, C., *et al.*: Clin. Med. 7:519, 1960. 2. Teitel, L. H., *et al.*: Indust. Med. 29:150, 1960. 3. Billow, B. W., *et al.*: Southwestern Med. 41:286, 1960. 4. Clinical Reports to the Medical Department, Armour Pharmaceutical Company, 1960. 5. Taub, S. J.: Clin. Med. 7: 2575, 1960.

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HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	872-1550
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
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KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office.	COlfax 4-0904
LAKEWOOD	Burke Rexall Drugs, Cor. 4th and Monmouth	FOxcroft 3-7133
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MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna Ave.	Cypress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-3800
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(Continued from preceding page)

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SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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